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**‘It’s a problem with the brain’: A discursive analysis of
parents’ constructions of ADHD**

PhD

Faculty of Health and Social Care

The Open University

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Chapter 1 Introduction

Background and rationale

My own interest in the topic of Attention Deficit and Hyperactivity Disorder (ADHD) developed in my practice as a children's counsellor in a primary school and as an adult counsellor with mothers of children identified as being 'at risk'. Many of these mothers had children diagnosed with ADHD or were seeking a diagnosis for their children.

It was particularly striking that in both contexts, within the family (as represented by the mother) and within the school, children's challenging behaviour was *apparently* being understood in terms of it being a medical condition located within the child. Both for mothers, and in schools, there seemed to be a 'taken for granted' understanding that the child's behaviour had a medical and biological aetiology. This, despite ADHD being generally understood to be a complex condition with many competing explanations for its causes, which I outline in Chapter 2. As an observer, the process of obtaining an ADHD diagnosis, whether sought by parents (in my experience, usually mothers) or by schools, seemed routine and entirely 'normal', even though a diagnosis of ADHD would indicate a child having a mental health disorder, as described in the Diagnostic and Statistical Manual of Mental Disorders (DSM) (see DSM – IV TR, 2000, and DSM – V, 2013) and would probably result in them having to take some form of stimulant medication.

It became apparent that there was a lack of congruence between my expressions of sympathy towards the news that the children of the mothers I was counselling had received a medical diagnosis and the mothers' own expressions of relief and satisfaction that a diagnosis had been given. Over the course of several months it became clear that a medical diagnosis was being actively sought by the mothers I

was counselling, and their determination in pursuing this was particularly notable. Mothers recounted how they sought, even demanded, second opinions if their GPs were not supportive of their requests for a referral for diagnosis. The mothers I met were skilled in commandeering expertise. The mothers' own developing expertise was notable, whether this was informed through online searching, through advice obtained from medical and paediatric professionals or through their own experience of dealing with their children. Significantly, it seemed that this developing expertise enabled mothers to confront doctors or other medical experts who did not support their request for an ADHD diagnosis.

I work as a psychodynamic counsellor and, clearly, within that role my attention is given to the experience and the story of the individual client. Despite acknowledging the uniqueness of each story, I could not shake off the sense that there was a pattern to these mothers' stories, a pattern that indicated a cultural and social influence to these accounts of mothering a child who, at least prior to diagnosis, was perceived to have 'anti-social' behaviour. Through my ongoing work with these mothers, I developed a feeling that these accounts of very pro-active mothering (pro-active in the way mothers took on an advocacy role for their children) were displays of 'good mothering' and that actually what these mothers were doing was seeking validation of their mothering. I became increasingly interested in how these mothers were managing to accomplish this through their accounts of struggle with doctors and health visitors, and of course why they were doing so.

It was only after I started my PhD and began my research into ADHD in the UK that I developed an understanding of the extent to which it is such a contested and controversial category. Prior to that, it was a category that was on the edge of my awareness, but not one I really knew or understood. Through my research I

realised that the counselling sessions that I was involved in were taking place against a backdrop of increased awareness of biomedical explanations of the disorder, diagnostic rates, increased medication and increased speculation that it was a 'fictional' disorder. Media coverage regularly conflated ADHD and anti-social behaviour. Parents were typically depicted as ineffective, and there was moral outrage over the use of medication to control the symptoms. In the next section I provide some details on this cultural and social context.

Biomedical framing of ADHD

Attention deficit hyperactivity disorder (ADHD) is characterised by pervasive and impairing symptoms of inattention, hyperactivity, and, and impulsivity according to DSM-IV. The World Health Organisation (WHO) uses a different name – hyperkinetic disorder (HD) – but lists similar operational criteria for the disorder. It has been associated with a broad range of negative outcomes for affected subjects and with a serious financial burden to families and society which characterises it as a major public health problem.

(Polanczyk, Silva de Lima, Lessa Horta, Biederman, Augusto Rohde, 2007)

The quotation from Polanczyk *et al.* (2007) provides a summary of the prevalent biomedical framing of an increasingly recognisable cluster of 'symptoms' typically manifested in childhood (although increasingly applied to adulthood). Reference to the DSM and WHO classification systems, coupled with the use of terms such as 'symptoms', 'criteria' and 'outcomes', points to the positivistic underpinnings of such medical classifications as ADHD. Viewing such phenomena through a positivistic lens, the focus is on discovering generalisable 'truths' regarding aetiology, symptoms, prognosis and treatment. This approach formulates medical categories as objective, neutral and universal, and, crucially, not at all informed by

social processes (see Harper, 1995). Consequently, the disorder is firmly located within the individual child. As a result, explanations are not sought within the child's environment. However, the quotation reveals how there is a (subtle) moral compunction to deal with (or treat) the condition because of its impact on the social environment. The inference is that, untreated, the disorder has negative consequences for the individual, their families and society in general.

Increase in diagnosis

Statistics relating to diagnosis vary considerably depending on location, method of recording and the classification system used, which raises issues of validity around the classification. However, despite issues of validity, all evidence points to significant recent increases in the numbers of children and young people diagnosed with ADHD globally, with as much as a 24% increase in diagnostic rates being reported in the USA between 2000 and 2010 (Nauert, 2013). Within the UK, the National Institute of Clinical Excellence (NICE) (2009) reports a rise in prevalence rates from 0.5 in 1000 schoolchildren 30 years ago to 3 in 1000 receiving medication in the late 1990s.

Certainly, over the last decade, ADHD has become one of the most prevalent (diagnosed) childhood psychiatric disorders in the world (Singh, 2008a; Remschmidt, 2005), with global prevalence rates amongst children ranging from 1-3% for hyperkinetic disorder (HKD), a more strictly defined version of ADHD as classified within the ICD -10, to 4-8% for ADHD, as diagnosed using DSM-IV criteria (Remschmidt, 2005).

In the United States, prevalence rates in schoolchildren are variously put at 5% (DSM V, 2013), 4-12% (The American Academy of Paediatrics cited by Schlachter, 2008) and even as high as 20-24% (Schlachter, 2008). Similarly, in the UK, prevalence rates range between 1.5% of school-aged children (Young Minds,

2013) to 2-5 % (NHS) to, 3-5% of children (McCarthy, Asherson, Coghill, Hollis, Murray, Potts, Sayal, De Soysa, Taylor, Williams, Wong, 2009).

An increase in prevalence rates is accompanied, unsurprisingly, by an increase in medication rates, particularly, the use of stimulants such as methylphenidate (Ritalin, Concerta and Equasym) and dexamfetamine (Dexedrine), which act on the central nervous system. In the UK prescriptions for Ritalin increased dramatically, from 6000 in 1994 to 461,000 in 2007 (Frankel, 2010). More recent figures suggest a four-fold increase in Ritalin prescription from 158,000 in 1999 to 661,463 in 2010 (Doward and Craig, 2012). According to recent media coverage, medication rates for ADHD within the UK have continued to increase. Typically, headlines have indicated a 'soaring' rise in prescription rates of Ritalin by 50% in six years (Donnelly, 2013; Meredith, 2013; Saul, 2013).

Despite ADHD's contested and controversial status, partly informed by the huge variance in diagnostic and prevalence rates, and concerns over medication, diagnosis of ADHD continues to rise globally and within the UK, the context for this study. This provides a rationale for further research into the ADHD phenomenon.

ADHD and the media

The use of the word 'soaring', referred to above, is one often deployed by the media in its discussion of ADHD diagnostic and medication rates. This is redolent of the style used to inform the media debate. Terms such as 'soar', 'sharp rise', 'astronomical numbers' (Swaine, 2013) are typically used in reports of the rise of ADHD and suggest a phenomenon which is out of control. This, in turn, contributes to a moral panic about precedence rates and over-diagnosis.

Although not all media coverage of ADHD is negative or exaggeratedly alarmist, ADHD remains a contested category with much of the discussion revolving around an unhelpful nature/nurture axis, which clearly has implications for parents. For

example, media representations of ADHD have often suggested that ADHD is a convenient label that parents (and teachers) seek in order to excuse their own inability to manage their child's difficult behaviour. Children have been portrayed as the victims of poor and irresponsible parenting. The parents, in turn, are portrayed as self-serving in their desire to obtain a medical diagnosis (see Horton-Salway, 2011, and Chapter 2 of this thesis for more detailed discussion of this). This was certainly a very prevalent argument four or five years ago, and although the media, in general, is a little more accepting of the category now, parents are still implicated in the current debates. A very recent article, links ADHD to a lack of exercise, and suggests that 'loving' parents would ensure their children exercise (Rayner, 2013).

Irresponsible parenting is not only implicated with causing and ill-managing the behaviour associated with ADHD, but also with seeking out medication. The health risks of stimulant medication are well-documented, not only in the media, but also in academic and therapeutic literature. Typically, unpleasant side effects are reported as including nausea, loss of appetite, a reduction in growth rates, a dulling of personality and even psychosis (see Frankel, 2010). The British media regularly features speculation on the long-term health risks of taking such medication (Meredith, 2013), and, typically, criticism has been directed towards parents who 'allow' their children to be medicated. Parents who administer the *chemical cosh* of Ritalin (for example, see Harris, 2013), or similar medication, are portrayed as being irresponsible and uncaring. More recently, parents have been accused of seeking medication in a bid to 'enhance their healthy children' (Swaine, 2013; Harris, 2013) and to improve performance at school.

These media representations are indicative of a prevalent understanding which aligns bad parenting with ADHD. This clearly places parents of children with

ADHD, including the mothers I worked with in my capacity as a counsellor, at the centre of a highly moralised debate.

ADHD and parents

The significant increase in diagnosis and medication of ADHD, and the subsequent positioning of it as a moral category, suggests that an investigation into current meanings and understandings of ADHD will be informative and useful. It provides a context for considering how ADHD is understood and constructed by the individuals affected by a diagnosis. As it is rarely young people who seek diagnosis of their behaviour, attention can be justly turned to parents, as it is they, along with teachers, who typically seek diagnosis. Research indicates that mothers pursue medical explanations for ADHD (Malacrida, 2001), often prepared to challenge their GP's opinion that their child does not have ADHD (Norris and Lloyd, 2000).

Interestingly, but perhaps not surprisingly, fathers were largely absent, both physically and anecdotally, in my counselling work with mothers. This absence is also apparent in the literature. The foregrounding of mothers in the literature relating to ADHD is interesting if we consider the gender imbalance in diagnoses. It is a diagnosis that disproportionally affects boys with, as yet, no clinical explanation. Research suggests that it is mainly mothers and female teachers that initially seek out diagnosis (Singh, 2008b). The little research there is on fathers suggests that, in addition to being absent throughout the ADHD diagnostic process (Singh, 2003), they are more sceptical of ADHD as a diagnosis and show resistance to interpreting their children's behaviour within a medical framework. As with the apparent take up of the medical model by mothers, the apparent reluctance to accept the medical model by fathers (Singh, 2003) suggests that

some distinct discursive work is being done in their construction of ADHD. I believe this merits further attention.

Theoretical approach to the research

My confusion over the responses of the mothers I was counselling led me to consider what the label ADHD meant to them, and to me, and to the teachers of the children I was also counselling (teachers' opinions varied between very confident 'lay' diagnoses of children to equally confident expressions of scepticism about the ADHD label). Clearly, people were not approaching the ADHD category as a fixed, objective scientific entity that had a neutral meaning; the label *did* things, hence the desire of the mothers I was counselling to obtain a diagnosis. Coincidentally, around this time I started a Masters module in discourse analysis at the Open University. My initial instinct that there was a socially informed 'patterning' to the way mothers sought medical diagnosis for their children and expressed relief once obtained, found 'a theoretical home' within discourse analysis. Key to this approach is the notion that human meaning making, manifest through such phenomena as ideas, concepts, experiences, and (medical) categories, does not only reflect the world, but constitutes it (see Willig, 2013; Burr, 2003; Wetherell, 2001a).

Within this tradition, **what** language does is as important as the **content** of language; language is considered to be performative and constructive. The idea of the disengaged, atomistic self who is understood to be expressing unique and personal beliefs is challenged (Davies and Harré, 2001) and language is understood to be infused with prevalent social and cultural discourses, which are taken up or undermined according to the performative work that is being accomplished. Discursive psychologists such as Billig (2001) highlight the rhetorical, dialogic and dilemmatic nature of discourse. Language is understood to

be argumentative and persuasive and often linked to criticism, justification and accountability in talk (Edwards and Potter, 1993:24). As Bakhtin suggests 'attitude statements tend to be uttered as stances in public controversy' (Billig, 2001:214), and are made in relation to counter positions, or alternative versions. This has clear resonance with the category of ADHD and its use by parents.

Within this approach medical classifications such as ADHD are not understood as fixed or static but are fluid and flexible depending on, and embedded in, the socio-cultural/historic/interactional context within which they emerge. Central to a social constructionist approach is the understanding that meanings around phenomenon such as ADHD are produced socially through social interaction. Medical classifications come into being through both the constitutive nature of language within the wider social environment, and also within the immediate social environment.

Such an emphasis, it has been argued, is especially suitable for the study of mental health categories (Harper, 1995). The dominant biomedical understanding of categories such as ADHD is underpinned by an individual-social divide.

Typically, with reference to ADHD, the 'problem' is understood to be located within the brain of the child. However, much literature, critical of the biomedical approach, emphasises the flexible and fluid nature of mental health categories (Avdi, 2005; Mcleod, 2001; Harper, 1995). Specifically, such medical categories are identified as being formulated within language and as emerging within the requirements of the situation in which they occur, whether it be a diagnostic process, a therapeutic situation or even a research interview. Clearly this has implications for diagnosis and treatment, particularly, if, as in the case of ADHD, the individuals seeking a diagnosis (the parents) are positioned within a moral debate.

1.2 Research aims

As Gillman, Heyman and Swain (2009) indicate, diagnostic labels are constitutive of people's lives and contribute to the construction of identity. The ADHD category is subject to critical and judgemental attention and is, unhelpfully, positioned as either a medical/biological phenomenon or one that is caused by a poor (parent provided) environment. This clearly has implications for the moral identity of parents. So, a discourse approach seems a particularly relevant one to draw upon in exploring how parents negotiate their understanding of ADHD, a disorder which is often subject to critical and judgemental attention.

The iterative nature of a discourse approach to analysis has implications for the framing of research questions. Data is repeatedly examined for discursive patterns, but the researcher does not know in advance what these may be, or what the significance of these may be. Taylor (2001a) suggests that the discursive researcher should 'have a confidence that there is something there but no certainty about what' (2001a:38). This obviously raises some tension in framing research questions. If reality and meaning are constructed through the talk itself, then imposing an explicit research question on the data collected undermines this epistemological position and risks imposing the researcher's frame of reference onto the very interaction which is being analysed (see Chapter 4 for a discussion of methodology).

Therefore, the research questions were quite broad in their scope. They were:

- How do parents talk about their experiences of ADHD?
- How, through discursive action, do parents construct their identities in relation to the meaning of ADHD?

To answer these questions, I identified three main research aims:

- First, to identify and analyse the discursive resources parents deploy in their constructions of ADHD, and their accounts of having a child with ADHD.
- Second, to consider the ways in which parents manage being morally positioned in relation to their children's ADHD diagnosis, specifically focusing on how parents rhetorically manage accountability.
- Third, to identify the (possibly distinct) cultural discourses that mothers and fathers draw upon in the formation of their identities as 'good' parents, and the way these resources are used in local interaction.

A cautionary note

A focus on constructions of medical classifications can implicitly suggest a challenge to the 'reality' of these conditions. Therefore, it is important to acknowledge the often distressing experience of those individuals and families who are affected by ADHD. Undoubtedly, the symptoms which belie an ADHD diagnosis can be extremely worrying and upsetting. However, whilst being sensitive to 'realist notions of individual distress' (Billington and Pomerantz, 2004), my research is not concerned with assessing the 'truth' about the causes and effects of ADHD, but is concerned with how ADHD is discursively produced and reproduced by parents and to what effect.

1.3 Chapter Overview

In this section I provide a brief overview of the structure of the thesis.

Chapter 2 this chapter will situate the category ADHD within the broader category of psychopathology and will review literature which offers social constructionist interpretations of the meanings around mental health categories. Within this framework it will chart the historical development of ADHD as a medical category and consider how changing explanations of 'ADHD type' behaviour contribute to

its controversial status. It will identify the key issues implicated in the dominant nature/nurture debate that surrounds ADHD, using the three areas of controversy as identified by Singh (2008a) as a framework for discussion; that is, diagnosis, the causes of the disorder, and, the ethics of medicating children. It will conclude by considering how parent identities are morally implicated in dominant understandings of ADHD.

Chapter 3 will take up the theme identified at the end of Chapter 2 and will review existing literature relating to parents and parenting. It will begin by examining literature that situates parents within wider debates about parenting, in particular those debates which pertain to issues of (moral) responsibility and gendered caregiving. It will then examine the literature relating to parents of children who are 'atypical' in some way before moving to a more focused consideration of the literature on parents of children with an ADHD diagnosis. It will consider the privileging of the maternal in existing literature.

Chapter 4 will present the theoretical and methodological framework of the thesis. It will begin by situating the discursive approach undertaken in this study within a social constructionist framework and show how this approach is particularly relevant for consideration of contested medical categories. It will proceed by arguing for a synthetic discursive approach, which incorporates fine-grain analysis with a consideration of the influence of wider cultural, historical and power relations (Seymour-Smith, 2008; Wetherell, 2007; Seymour-Smith and Wetherell, 2006). It will introduce the key analytic concepts and tools which will be used in data analysis. Data collection and my approach to analysis will be described. The chapter will conclude by reflecting on some of the ethical considerations raised by the research.

Chapter 5 is the first data analysis. This chapter uses the analytic concept of interpretative repertoire (Edley, 2001a; Potter and Wetherell, 1987), to explore the different discursive resources drawn upon by the parents in this study to talk about their experiences of having a child with ADHD. In line with the synthetic approach adopted for this study, it also presents a more fine-grained analysis of the epistemological and action-orientation (Potter, 1996) of parents' talk in interaction. It considers how different discursive resources make available different subject positions for the parents.

Chapter 6 and Chapter 7 focus on how mothers are formulated as morally accountable, good mothers through talk which makes relevant the historically prevalent, binary subject positions of 'blameworthy' and 'valorised mother'. Chapter 6 examines how mothers' accounts manage the blameworthy mother subject position and Chapter 7 will examine how mothers work to construct themselves as good (valorised) mothers. Specific emphasis is placed on the discursive techniques used by mothers to resist or undermine being positioned as responsible for their children's disorder, and equally, on the techniques used by mothers to construct themselves as morally adequate, 'good' mothers.

Similarly, **Chapter 8** looks at the way fathers are formulated as morally accountable, good fathers. It considers the subject positions that are made available to fathers through the distinct ways of talking about ADHD and it identifies which positions are made salient and how. It acknowledges that sceptical understandings of ADHD emphasise the cause/effect relationship between a lack of discipline and ADHD. It also acknowledges that this argument is typically gendered and implicates fathers with notions of discipline. These themes are explored in the analysis.

Chapter 9 offers some reflections on how the procedures of data collection and analysis might have affected the data itself, and the subsequent interpretations.

In **Chapter 10** the findings of the thesis are summarised and the research contributions to the respective bodies of literature are considered. Finally, I consider some of the limitations of the research and make suggestions for future research.

Chapter 2 The Category of Attention Deficit Hyperactivity Disorder (ADHD)

In DSM – IV, each of the mental disorders is conceptualised as a clinically significant behaviour or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. [...] It must be considered a manifestation of a behavioural, psychological, or biological dysfunction in the individual.

DSM – IV TR (American Psychiatric Association, 2000)

As outlined in the introductory chapter, the prevailing understanding of ADHD within Western society is that it is a neurodevelopmental disorder which manifests itself in particular maladaptive behaviour in relation to three areas of functioning, impulsivity, hyperactivity and inattention. This understanding is codified within the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (or the DSM), the most recent edition of which is the DSM V, 2013. Its presence within this manual positions it as a mental health disorder, a definition of which is provided by the DSM and reproduced above. As the DSM identifies, mental disorders are defined by a variety of concepts such as distress, dysfunction, disadvantage and statistical deviation. In constructing ADHD as a mental health disorder, this places it within the realms of psychopathology, a complex discipline, with diverse theoretical perspectives.

Within Western society, the DSM, along with the World Health Organisation's International Classification of Diseases, ICD – 10 (WHO, 2010), provides psychiatric and scientific authority to clinical understandings, diagnosis and

treatment solutions of behaviour identified as being 'disordered'. The authority which is inherent in such scientific classifications can obscure the problematic and contentious issues of psychiatric diagnosis, classification and psychopathology.

This chapter begins by considering some of the broader issues surrounding psychopathology and the diagnosis and classification of mental disorders. It will then examine issues specifically relating to ADHD.

2.1 Shifting notions of psychopathology and mental disorders

Inherent to the identification and classification of a mental health disorder is the assumption that the concept of mental health (without disorder) is understood and shared by all. As indicated by the extract from the DSM shown above, mental disorders are defined through the language of deficit, impairment and lack of control: **dis**ability, **dys**function, **dise**ase, **dis**advantage, **dist**ress (*dis* in Latin meaning apart and *stress* coming from the Latin *stringere*, meaning draw tight). However, the antonyms of these qualifying criteria of mental disorder, that is, ability, function, ease and advantage are not criteria that are used to define and classify mental health. Indeed, definitions of mental health are rarely provided in any context. Rather, mental health can be understood as the absence of maladaptive symptoms, it is thus unnoticed, undefined and invisible.

The definition of mental health disorders provided by the DSM and shown above acknowledges behavioural, psychological or biological dysfunctions as being possible causes of disorder. Prevalent expert understandings of ADHD position it within the discipline of neurobiology, and thus it is formulated as having an organic and medical aetiology and, thus, treatment 'pathway'. However, unlike physical medical disorders, in which diagnosis is usually sought by the individual who is suffering, and whose suffering is, significantly (and typically), contained within themselves, diagnosis of mental health disorders are often sought by others

because social norms have been violated (see Lemma, 1996; Laing, 1960).

Mental health disorders typically have a social basis for their identification and in some situations mental health disorders are also subject to political formulation, as evidenced by the political use of psychiatric diagnosis in Soviet Russia. Examples such as this highlight the contentious and powerful effects that the deployment of mental health categories can have. Unsurprisingly, the field of psychopathology is a contentious one, charged with debate about the role and the relevance of psychiatry. Critique of psychiatry emanates specifically from the distinct anti-psychiatry and critical psychiatry movements.

Headed by people such as Szasz (1974) and Laing (1960), the anti-psychiatry movement, which emerged within the 1960s and 1970s, argued that mental illness was a label attached to non-conforming individuals who transgressed social norms, a stance that resonates with Conrad's (2006) position on ADHD (see later in chapter). According to Szasz, and others within the anti-psychiatry movement, mental illness is a myth, not a disease (see Hopton, 2006). Consequently, within such an approach, the legitimacy of medical diagnoses and interventions in relation to mental distress is challenged. Medical intervention is considered appropriate for the diagnosis and treatment of 'material' disease of the body. Mental distress, on the other hand, requires a distinct knowledge base and a therapeutic approach which encompasses a 'moral education' (Bracken and Thomas, 2010). The body/mind binary distinctions of Szasz' anti-psychiatry position (Bracken and Thomas, 2010) are not taken up by the critical psychiatric movement. Indeed, it resists the Cartesian separation of mind and body, arguing that mental distress does not lead to suffering in two different modes. Unlike the anti-psychiatry movement, the critical psychiatry movement is less concerned with challenging mainstream psychiatry's basic assumptions, and does not challenge the legitimacy of a biomedical approach in relation to mental distress. Rather, it

interrogates and resists the 'purely medical framing' of such states (Bracken and Thomas, 2010: 223), which is particularly evident in contemporary Evidence Based Medicine (EBM) (see Thomas, Bracken and Timimi, 2012). Central to this movement's critique is an understanding that a biomedical approach to mental distress does not offer the 'whole picture'. Psychiatry and EBM, it is argued, perceive mental health work 'as a series of discrete interventions targeted at specific malfunctions in our biological or psychological make-up' (Thomas, Bracken and Timimi, 2012: 296). This, ignores (or at least, side-lines) the role of culture and meaning in the experience of mental distress and mental health practice. The critique put forward by the critical psychiatry movement is a significant one for the approach taken in this thesis, and resonates with the Foucauldian approach; in particular, the role of history and culture on the formation of meaning around medical and psychological categories. An outline of this approach in relation to ADHD will be given later in this chapter.

Inherent to the purely biomedical perspective within which mental health disorders are typically constructed is the idea that scientific and medical classifications are objective and value free. However, the critical psychiatry movement highlights the subjective basis of judgement and the fluctuating understandings of 'disordered' behaviour between different individuals, institutions, countries and historical periods. The subjective basis of diagnosis is highlighted by Lemma (1996), who indicates that diagnostic criteria is informed by 'value terms' such as 'good', 'failure', 'disturbance'. The terms used to describe the diagnostic criteria of ADHD include 'persistent', (how often is persistent?), '*some* impairment' '*some* hyperactive-inattentive' (what is meant by *some*?), 'fails', 'has difficulty' (both 'fail' and 'difficulty' require external, subjective judgements about the 'quality' of performance of a task). As Lemma (1996:4) points out, 'everyone performs actions that do not correspond with our definitions of normal behaviour but that only in

certain circumstances do they receive a stigmatising label'. Other researchers concur; for example, Littlewood and Lipsedge (1998) suggest that it is not necessarily specific behaviours that confer pathological labels but their manifestation within prescribed social contexts. As an example, they consider how hallucinations within certain religious contexts are not considered problematic but an indication of spiritual expression whereas hallucinations are typically provided as diagnostic criteria of dementia or schizophrenia within the DSM.

These changing social interpretations of mental health disorders indicate that psychopathology does not lie within a value-free scientific framework, but emerges within changing socio-cultural and political contexts. Lemma (1996) outlines the shifting historic understandings of psychopathology and charts how diverse social institutions have shaped society's understandings of madness and deviant behaviour. As Foucault (2003, 2006) outlines, madness and sanity have been defined and treated throughout history by institutions such as the church, the law and, in current society, by medicine. The somewhat vague term mental illness, for example, has been variously understood in terms of it signifying the presence of a certain kind of wisdom regarding the human condition (Oksala, 2007), the presence of evil spirits, a loss of divine grace, a failure in morality (Foucault, 2006), having a poor maternal attachment (Klein, 1997; Fairbairn, 1952), and a biochemical imbalance. Lemma (1996) gives an example of anorexia, which at various points in history has been formulated as saintliness, hysteria, sickness and madness. As well as diagnosis, the treatment of mental health disorders can also be understood within the socio-cultural context in which they are located. Fernando (1991) suggests that within the West, health is attained by control and domination of illness whereas within African and Asian countries health is attained from acceptance.

These different interpretations of what constitutes psychopathology and how it is best treated seemingly indicate that mental health disorders such as ADHD are embedded and emerge within diverse social contexts, a fact largely ignored by the DSM. However, the DSM does acknowledge the slipperiness of defining mental health disorder. As it states, 'no definition adequately specifies precise boundaries for the concept of 'mental disorder'. It also acknowledges that there is a lack of 'a consistent operational definition that covers all situations' (American Psychiatric Association, 2000:xxx). It is within such a controversial discipline that prevailing meanings of ADHD are formulated and many of the issues briefly outlined above, in relation to the broad theme of psychopathology and mental health disorder, are also raised in relation to ADHD, which is the focus of the rest of the chapter.

2.2 ADHD: The historical construction of a controversial category

According to NICE (2009), and as cited by Horton-Salway (2011:533), 'the definitions of ADHD and hyperkinetic disorder are based on maladaptively high levels of impulsivity, hyperactivity and inattention.' Despite this fairly neat classification, it is also well documented that ADHD is a contested category within existing clinical, academic and popular literature (Horton-Salway, 2011, 2012; Rafalovich, 2005, 2008; Singh, 2002b, 2008a). Rafalovich refers to the 'vagueness' of the disorder and suggests that as a consequence of this vagueness (and no doubt also contributing to this vagueness) 'our contemporary discussion of ADHD is represented by a plurality of views: academic, clinical, pop cultural, journalistic and so on' (Rafalovich, 2008:2).

Existing literature points to the historically shifting explanations and accounts of childhood hyperactivity and restlessness (Conrad, 2006; Mayes and Rafalovich, 2005, 2007; Singh, 2002a) and these accounts contribute to the existing controversial and contested status of ADHD. As Mayes and Rafalovich (2007:435)

suggest, although the behaviours in question are similar, the diagnostic labels used have changed due to ‘cultural, medical and scientific changes and discoveries’.

Organic roots of morality

Rafalovich (2001b) adopts a Foucauldian framework to trace the conceptual history of ADHD and the changing notions of childhood mental health disorders. Although Foucault’s concern was with changing scientific meanings of the criminal (Foucault, 1991), Rafalovich argues (2001b:102) that ‘this process of seeking the essence of the deviant through scientific study encompasses virtually anyone who has persistent troubles with conventional institutions. Within the discourse of imbecility during the later 19th and early 20th centuries there was particular attention given to children.’

This is exemplified by Still’s 1902 classification of ‘the moral imbecile’, which suggested an organic and neurological ‘cause’ of socially inappropriate, immoral behaviour in children. This classification of problematic and persistent presentations of symptoms similar to hyperactivity, restlessness and inattention has since been subject to at least twenty category label changes (Mayes and Rafalovich, 2007). The labels that have had most purchase include Tredgold’s category of ‘feeble-mindedness’ (see Hall, 2008) and post *encephalitis lethargica*, (or ‘sleepy sickness’ as it was known, which emerged as an epidemic in the late 1910s and continued into the 1920s). An association between children who had survived the epidemic *encephalitis lethargica* and inattention and restlessness was identified, and this was attributed to defective neurological impulses, brought on by the condition. Both of these classifications identified certain symptoms, such as irritability, obstinacy, inattention, and general hyperactivity (see Rafalovich, 2008) as indicative of moral difficulty in childhood, and both categories situated the

cause of this deviance within the child's physiological pathology. Interestingly, the maladaptive behaviour of these children came to light within institutions such as school, and manifested itself in behaviour that was considered inappropriate to these contexts. As Rafalovich (2001b:110) states:

The moral imbecile child portrayed by the medical discourse of the late 19th century was eclipsed by the much more elaborate analysis describing the postencephalitic child. The diagnosis of encephalitis lethargica provided a physiological explanation for unconventional, antiinstitutional child behavior.

Rafalovich (2001b) argues that many scholars working within the field of child psychology and with an interest in ADHD interpret the shift of focus from moral imbecility to neurological dysfunction as indicative of scientific progress. However, he suggests that to view changing classifications of mental health disorders as the onward march of science obscures other possible variables. For example, he points to possible environmental factors influencing the manifestation of postencephalitic behaviour in children as many of the children identified as postencephalitic had been institutionalised prior to their identification. Drawing upon Goffman's looping effect (1961), he queries whether psychiatrists interpreted children's resistance to their institutional environment as symptomatic of mental disorder.

During the 1930s, 'deviant' and institutionalised boys were still the subject of scientific enquiry and children with mental health disorders were now subject to increasing interest in the effects of medication on their disorders. In 1937, Charles Bradley undertook a study to examine the effect of stimulant medication (Benzedrine) on a group of hospitalised boys with a variety of mental health disorders. Of interest to the scientific community was the 'discovery' that such medication had a significantly positive impact on the performance of these boys at

school and on their social skills. Clearly, this would lead to new avenues of scientific/biological exploration.

Indeed, interest in the effects of medication continued in the following decades and in the 1950s Ritalin was first tested on children. According to the psychiatric and medical community, the positive response of children to the medication provided evidence of the organic/biological roots of the disorder (Mayes and Rafalovich, 2007; Singh, 2002a,). The 1950s saw the emergence of the label hyperkinetic impulse disorder (Laufer, Denhott, Solomons, 1975), which again was attributed to an organic cause, specifically, a damaged diencephalon (the region at the upper end of the brain stem implicated in the regulation of the central nervous system).

However, despite the ever-changing but persistent presence of biological explanations for childhood behaviours, the early to mid-twentieth century saw the increasing influence of psychoanalytic interpretations of childhood behaviours. Psychoanalysis was very much concerned with mother/child relations and the effect of mothering styles on children's emotional, psychological (and economic) outcomes (Singh, 2002a). Clearly, within this framework, a child's emotional and psychological well-being was affected by their social/familial environment. Indeed Bradley himself combined psychoanalytic thinking with biomedical exploration of stimulant medication to account for the behaviour of the institutionalised boys and his view both represented prevailing discourses, and was reproduced within popular culture. As Singh (2002a:590) points out, 'throughout this period of experimentation with Benzedrine the possibility of mother's toxicity and the necessity for separating mother and child went unchallenged in published articles.'

Emotional disturbance and environmental factors

Within psychoanalytic thinking, mothering styles and the presence (early 1950s), or absence (late 1950s) of discipline were very much implicated in successful child

outcomes (Mayes and Rafalovich, 2007; Singh, 2002a). The term 'emotional disturbance' came to be used in the 1950s to describe behaviour which included hyperactivity, inattention, moodiness, delinquency and impulsiveness (Singh, 2002a). Although a particularly vague term, the consensus was that emotional disturbance was a secondary symptom of an underlying disorder, which if 'unattended' would lead to the, so described, 'disturbed' behaviour. Clearly, the responsibility was with the mother to be vigilant and 'pick up' on the underlying disorder and, as a result, to manage it and thus avoid its mutation into disorder, or alternatively, to seek treatment for it.

The influence of psychotherapy and the shift from biological/neurological explanations of childhood disorder to considerations of environmental influence is revealed by the shifting classifications of inattentive and hyperactive behaviour which emerged in the 1950s and 1960s. Although the brain was implicated in these labels, it was modified by the adjective *minimal*, as in minimal brain damage and later, minimal brain dysfunction. Minimal brain dysfunction (MBD) attributed the cause of dysfunction within the child's central nervous system to factors such as genetic, biochemical, perinatal brain damage or, crucially, 'from unknown causes', which presumably, can include a myriad of (social or environmental) causal factors (Clements, 1966, cited in Mayes and Rafalovich, 2007:448). According to Singh (2002a) the term MBD was more prevalent in scientific literature, while the term 'emotional disturbance' was used more in popular literature, but, despite the fact that MBD was understood to be caused by organic factors and 'emotional disturbance' by anxiety and conflict, they became closely entwined with one another. The influence of psychotherapy at this time is also reflected in the language used by the DSM-II (1968) in which all childhood disorders were described as 'reactions' to childhood (Mayes and Rafalovich,

2007), and specifically, the ancestor of today's ADHD classification was the label 'hyperkinetic reaction of children'.

Coinciding with increasing academic and media critique of the use of stimulant medication on children (Conrad, 2006), explanations for childhood hyperactivity continued to be sought in the 1970s within the external environment of the child, as evidenced by the popularity of Feingold's 1974 book 'Why Your Child is Hyperactive' (Feingold, 1974). However, although psychoanalysis broadened the debate about the causes of childhood disturbance, medical and scientific explanations continued to flourish.

The persistence of biomedical explanations

In 1980, the classification Attention Deficit Disorder entered the DSM III (1980), and as Mayes and Rafalovich state (2007:437), 'inserted a degree of psychiatric legitimacy into the discussion of childhood hyperactivity and impulsivity'. However, the DSM's definition of what constitutes ADHD has changed four times since it first appeared in the DSM in 1980. The DSM-IV-TR expanded the symptoms and criteria of ADHD, and as Schlachter (2008:155) indicates, 'no other childhood psychopathology has undergone as much renaming and reconceptualization as the hyperactive disorder'.

Scientific truth or social construct?

As mentioned earlier, one way of interpreting the changing nature of classifications is to suppose that medical knowledge becomes more sophisticated and discovers 'better truths' about its subject matter. As Tait (2001:98) suggests, the emergence of a new medical category, such as ADHD, is presented (and accepted) as the discovery of a pre-existing truth. Medical categories, he argues, present themselves as being 'objective, benevolent and teleological' and are crucially disembedded from the historical contexts and discourses in which they are

produced. However, he argues, from a critical perspective (see Chapter 4), it is more pertinent to consider that scientific 'truths' (or medical labels) both shape and are shaped at a societal level; that truth is contingent or relative to some discursive or cultural frame of reference. As Foucault maintains (2003, 2006), concepts such as madness and deviance cannot exist, or not be maintained without recourse to the prevalent discourse of the time. Within this perspective, such categories are not static but discursively formed according to the historicising discourse (Hall, 2001). The changing understandings of childhood hyperactivity and impulsivity, for example, point to the flexibility of medical labels and indicate that such classifications are open to negotiation, and socially created (see Conrad, 2006; Tait, 2001) rather than them being fixed and impenetrable, or even 'dormant', waiting to be discovered. The classification of children's mental health disorders has not evolved entirely from new discoveries, but through changing cultural and historical ways of understanding and categorising children's behaviour (Singh, 2008b; Timimi, 2007). Current understandings of ADHD have emerged within a time of shifting socio-cultural practices; as outlined by Timimi (2007), children are experiencing a far more intense focus on school performance, a diet consisting of more processed foods, changing family patterns, less physical activity whilst family life in general is subject to increasing institutional surveillance and a narrowing of behaviour considered acceptable (Timimi, 2007). Mayes and Rafalovich (2007) and Singh (2002a:598) call for an understanding of the discursive processes by which 'social and behavioural norms become codified in psychiatric categories', and by which ADHD has become constituted as an object.

Discursive threads of morality and criminality

It is clear that certain discursive threads have permeated throughout the twentieth, and indeed, twenty-first, century in relation to children's (mainly) hyperactive and inattentive behaviour. Historically, this behaviour was linked with a lack of morality

and this emphasis continues today with much academic and media interest focusing on the association of ADHD with criminality. Existing literature includes studies concerned with the effects of medication on criminality (Lichtenstein, Halldner, Zetterqvist, 2013), longitudinal studies concerned with the impact of ADHD on adult delinquency (Mordre, Groholt, Kjelsberg, Standstad, Myhre, 2011), and studies which explore the predictive risk factors for children with ADHD and the likelihood of future criminal behaviour (De Sanctis, Nomura, Newcorn, Halperin, 2012). One of the gendered media representations identified by Horton-Salway (2012) is the male ADHD 'villain', who is formulated as out of control, violent and dangerous.

Over the course of the last century, explanations for this deviant or immoral behaviour have been sought within the organic make-up of the child and/or within the child's domestic environment, the latter of which very much implicates the family and, historically, the mother in particular. As outlined above, the legitimacy of the scientific/medical label is one that has been taken up throughout the Western world as evidenced by the rising prevalence rates, but this has coincided with prevalent and popular psychological discourses which have held mothers responsible for the 'outcomes' of their families and children. Singh (2002a) charts how scientific practices have entered the domestic space and how a turn to science (or medicine) absolves mothers from blame for family deviance (or childhood misbehaviour). Conrad (2006) also suggests that at a broader, societal level, the medicalization of childhood deviance diverts attention from possible societal influences, and furthers the individualisation of social problems. The individualisation of social problems is very much aligned with current neo-liberal ideology, which again, portrays ineffective parenting as the root of all anti-social behaviour (see Chapter 3). This time parents (and mothers specifically) are implicated within political discourse (as opposed to the psychological discourse of

earlier times) with their children's disorder, and medicalization of 'disordered' childhood behaviour provides a release from condemnation and stigma (Conrad, 2006) as the understanding of the deviant behaviour shifts from one of 'badness' to one of 'illness'. As Conrad (2006:5) states, 'with badness the deviant was considered responsible, with sickness he is not'.

These discursive threads are still apparent in current representations of ADHD, and contribute to an uncertainty about what exactly ADHD is, and what its causes are. According to the literature, it is not only lay people who are uncertain about the disorder; medical experts also demonstrate 'a profound epistemological uncertainty' (Rafalovich, 2005:306) in diagnosing and offering treatment (see also Conrad, 2006). Medical uncertainty exists around the context specificity of the criteria; namely, the identification of behaviours within school settings and also the fact that there is no clinical validation of the disorder (Conrad, 2006; Rafalovich, 2005). Instead, current diagnosis of ADHD is formed by identification of a cluster of behavioural symptoms (see next section).

The vagueness of the ADHD category is also manifest in the varying definitions of the disorder. As Horton-Salway (2011:534) points out, in 2008 alone:

ADHD was described as a genetic disorder (Wallis et al., 2008) a biochemical imbalance (Tripp and Wickens, 2008) and a neuropsychological disorder (Sugalski et al., 2008). ADHD was also defined as a personality disorder (Eisenbarth et al., 2008) or an oppositional defiant disorder related to autism (Gadow et al., 2008). Others described ADHD as a psycho-social disorder (e.g. Knight et al., 2008).

Singh (2008a) argues that there are four positions taken in relation to ADHD. The first position maintains that ADHD has a biological aetiology, specifically, a

neurochemical imbalance. Consequently, diagnosis and medication are justified. The second position is that ADHD is caused by a combination of biological and social factors. According to Singh, holders of this position accept a judicious use of medication, but also advocate for other therapeutic interventions to be used. The third position is that ADHD is a valid disorder but is caused by factors in the environment, such as poor diet and maternal smoking. Holders of this position seek to limit the prescription of medication through preventative measures such as education and raising awareness of 'predisposing environmental factors' (Singh, 2008a:958). The fourth position is one that is sceptical of ADHD being a real disorder. In particular, Singh suggests that current controversy over ADHD revolves around three areas: diagnosis, the causes of the disorder, and, the ethics of medicating children. So, it is a very noisy site, one with many competing theories about what it is, what causes it and how it is best managed.

It is not the aim of this research study to formulate a precise definition of ADHD, or, indeed, to become engaged in the increasingly polarised myth/reality debate that surrounds the category ADHD (Bailey, 2010). The aim of the rest of this chapter is to provide an overview of current medical and socio-cultural representations of ADHD, specifically in relation to the three areas of controversy (diagnosis, causes of ADHD and medication) identified by Singh (2008a). It will also consider how these representations morally position the individuals implicated by the category.

2.3 The controversy of diagnosis

The biological (medical) model

Gray (2008) highlights how the biomedical construction of ADHD is rooted in scientific and positivist epistemology which 'maintains that greater scientific study and empirical investigations will yield further advances in understandings and

knowledge about ADHD' (Gray, 2008:17). This perspective, she argues, is the dominant approach in contemporary Western understandings of medicine and is concerned with increasingly precise disease classification, diagnosis and treatment. The biomedical understanding of ADHD is one that is represented within prevalent classification systems relating to mental disorders, principally, the American Psychiatric Association's (APA) DSM – V (2013), which has recently superseded the DSM-IV T-R (2000). A less used, but still quite prevalent classification system is the World Health Organisation's (WHO) International Classification of Diseases – 10 (ICD-10, 1992). Significantly, ADHD as such does not appear in the ICD – the closest diagnosis being hyperkinetic disorder (or HKD). Diagnosis of HKD requires identification of more symptoms than ADHD and does not allow for HKD to be co-morbid. This is arguably why diagnosis of ADHD was 3-4 times more probable using DSM – IV criteria than when using ICD-10 (Singh, 2008a). The latter was the preferred system used in the UK (and Europe) but, increasingly, the DSM is being used in the UK (Bailey, 2010). For this reason, discussion of ADHD in this study will, unless stated, refer to the condition as it is classified by the DSM – IV TR (2000) and DSM – V (2013). In particular, this study draws on the DSM – IV (2000) as this was the 'current' manual at the time of data collection, the DSM –V (2013) not having been published until the time of writing up.

ADHD diagnosis is most usually applied to children and consequently, it is often referred to as a childhood disorder. However, it is increasingly being recognised as a lifelong disorder which, by definition, clearly, also affects adults (Conrad, 2006). The definition of ADHD contained within the new DSM – V has been changed to reflect this shift in understanding. Although the criteria have not changed, the DSM-V provides guidance on the diagnosis of adults, in particular, offering examples of how older adolescents and adults might behave. By including adults

in the remit of the category, the context specificity of the criteria is lessened to incorporate more 'adult' contexts, such as employment (American Psychiatric Publishing, 2013). There is also a slightly lower criteria threshold for a diagnosis to be made with adolescents and adults compared to children.

Diagnosis is based on a psychiatric assessment of behaviour. Hyperactivity, impulsivity and attention problems are the three areas of impairment attributed to ADHD. ADHD is diagnosed through a behavioural checklist provided by, at the time of data collection, the DSM –IV TR (and latterly the DSM-V). The DSM –IV TR/DSM-V organise eighteen diagnostic criteria into three groups; behaviour that relates to inattention (nine criteria), behaviour that relates to hyperactivity (six criteria), and, behaviour that relates to impulsivity (three criteria). According to the DSM-IV there are three possible subtypes of ADHD: ADHD–combined type, ADHD–predominantly inattentive type, and ADHD–predominantly hyperactivity/impulsivity. For a diagnosis of one of these subtypes to be made, *some* (but not all) of the symptoms must have been present before 7 years (although this has just been changed to 12 years in the DSM-V) and *some* of the symptoms must be present in 2 or more settings. The most common diagnosis of ADHD in the UK is ADHD-combined type (NHS, 2012). Despite the fact that for a diagnosis of ADHD to be obtained some symptoms should occur across 2 or more settings, many of the criteria listed in the DSM-IV TR (and still the DSM-V despite the addition of work-based references) refer to behaviour that is problematic within the classroom: getting out of one's seat and wandering around the classroom is one example, as is a failure to pay close attention to details or making careless mistakes in schoolwork.

Through the process of scientific classification, categories such as ADHD come to be understood as discrete conditions, with recognisable and specific aetiologies,

prognoses and treatments (see Gray, 2008). However, the discrete 'nature' of ADHD can be challenged through its high levels of co-morbidity with other conditions such as conduct disorder, oppositional defiant disorder and anxiety disorders (NICE, 2009; Singh, 2008a). Uncertainty and vagueness around diagnosis and ADHD are further added to by the considerable variation in ADHD prevalence rates both between and within countries.

Variation in prevalence rates

There is much international and national variation in diagnostic rates. Countries with a high prevalence rate include the US, Australia, Canada, Iceland and, increasingly, South American countries (Singh, 2008a). In 2008, lowest prevalence rates were within the European countries, and indeed, lower rates of prevalence in Europe, compared to the USA have been well documented in the literature (Polanczyk *et al.*, 2007). This difference is, perhaps, a legacy of the fairly powerful anti-psychiatry movement within Europe and the UK in the 1960s and 1970s. Indeed, the prescription of stimulants to control hyperactive behaviour started in the US during the 1960s whereas in the UK it only really started during the 1990s. Lower rates are also, no doubt, reflective of Europe's preferred use of the ICD-10 classification system, with its more stringent criteria (Remschmidt, 2005). As Schlachter (2008:156) indicates, 'the slight variances in criteria play a large role in the predominance of the disorder in populations.' Increasingly the DSM-IV TR (and presumably, now DSM V) is being used within the UK, and this may account partially, for the increase in prevalence rates suggested by the recent media coverage which reports a 50% increase in Ritalin prescription in the UK over the last six years (Saul, 2013; Donnelly, 2013; Meredith, 2013).

Variation in prevalence occurs within countries as much as it does between countries. The American Academy of Paediatrics suggested that in 2008 between

4-12% of American school children were affected by the disorder (Schlachter, 2008) whereas other estimates suggested a prevalence of between 20-24% in the US (Schlachter, 2008:157). The variation in UK prevalence rates is clearly highlighted by the range of statistics provided by the literature. In one 2009 study, ADHD was said to affect 3-5% of children (McCarthy *et al.* 2009), whilst more current literature suggests prevalence rates are between 2-5% of UK school children (National Health Service, 2012) or 1.5% of school children (Young Minds, 2013). Indeed, so diverse are statistics relating to ADHD, that Singh (2008a) suggests UK prevalence rates vary between 0.5% and 26% of school children, depending on regional diagnostic practices. For example, as Frankel (2010) indicates, in the UK, Wirral primary care trust (PCT) 'dispenses one Ritalin prescription for every seven children under 16' (she does point out that this includes repeat prescriptions and does not equate to one in seven children) whereas in Stoke-on Trent, the rate is one prescription for every 159 children. Regional variations in diagnostic rates of ADHD highlight the arbitrary nature of diagnosis; whilst some of this difference can, perhaps, be explained by differences in referral systems, it also raises the possibility that the DSM classification of ADHD is very much dependent on subjective interpretation of behaviour. As Stolzer (2009:6) suggests 'tolerance level, understanding of normative developmental processes, gender, age, personality type, education, individual perception, and cultural background are all factors that influence rater perception'. Indeed, inconsistency in methods of diagnosis and epidemiological studies is identified as a significant factor in relation to issues of validity concerning the ADHD medical category (Singh, 2008a; Polanczyk *et al.* 2007). Singh (2008a) cautions against dismissing ADHD as a mythical scientific category because of the discrepancies in prevalence rates and, rather, distinguishes between the causes of ADHD and the causes of over and under diagnosis. She suggests that diagnostic

rates are informed by socio-cultural factors and calls for a consideration of these. Within the macro environment, she considers diagnosis to be mediated by the influence of the pharmaceutical industry, and government resources and benefits to parents and schools. Within the micro environment, she considers diagnosis to be influenced by pressure within schools, socio-economic status, cultural trends, ethnicity, geographic factors, and parental expectations. A brief discussion of these factors follows.

The influence of the pharmaceutical industries

Certainly, it would appear that a factor influencing the prevalence of ADHD diagnostic rates is the phenomenal growth of the pharmaceutical companies and their aggressive marketing of medication to help control the behaviours associated with ADHD. One of the most prominent pharmaceutical providers in the US, Novartis, formerly Ciba-Geigy, financially supports the most significant American ADHD organisation, CHADD (Children and Adults with ADD) and funds research which frames ADHD as a medical disorder (see Conrad, 2007). Ritalin advertisements are common in popular US magazines (Singh, 2002a) and a search on the Internet for 'Ritalin' will produce many sites from which it is possible to purchase the drug without prescription. Although the turn to medication has been slower and later in the UK, it is perhaps significant that the period that witnessed the steepest increase in the number of methylphenidate prescriptions (1991 to 1996 with a rise of over 2000%) coincided with the appearance of Ciba-Geigy, the largest provider of methylphenidate, in the UK (Norris and Lloyd, 2000).

Pressure within schools

As outlined above, many of the diagnostic criteria necessary for an ADHD diagnosis relate specifically to an educational context and Singh (2008b) suggests

that schools and schooling are one of the mediating cultural contexts which contribute to the development of diagnosis and medication treatment for ADHD.

With so many of the criteria necessary for an ADHD diagnosis relating to behaviour within the classroom, it seems pertinent to ask whether schooling produces certain problematic behaviours. Certainly, as we have seen from the DSM –IV TR, the school context is implicated in the diagnosis of ADHD within certain cultures. Even the DSM cautions against diagnosing pre-school children as it is common for this age group to be very active and lacking in self-control; it is only within the discipline and routine of the school environment that ADHD symptoms stand out, partly, no doubt, because children, by this age, are supposed to have learned self-control. Arguably, and more specifically, as Singh (2008b) points out, the problematic behaviours are only a problem within the confines of the classroom; they are not so much a problem in the playground. She raises the question of whether expectations of behaviour within the classroom are reasonable. Teachers have less recourse to disciplinary measures than they did, and so children are expected to exercise self-control and self-regulation.

Similarly, medication of ADHD predominantly coincides with the school years despite the fact that medical evidence suggests that it is not a time limited condition (Barkley, 2002). Recent data obtained from the UK General Practice Research database (McCarthy *et al.*, 2009) suggests that the prescription prevalence for 21 year old males was 95% lower than that for 15 year olds. In addition, in a longitudinal study of 44 patients aged 15 and prescribed Ritalin, not one remained on treatment at the age of 21. According to this data, the steepest decrease in prescribing medication is between the ages of 16 and 17, often coinciding with school leaving age. There are several possible reasons for this decline in prescription rates: one possibility is that individuals become better able

to manage their conditions and develop coping strategies as they become older; another possibility is that this decrease reflects the discontinuity of care of the young person between child and adult mental health agencies (Singh *et al.* 2008). However, yet another possibility is that once the young person has left full-time education, the symptomatic behaviours become less problematic. As McCarthy *et al.* (2009:275) suggest, it could signal that 'the need for sustained attention and focus or control over hyperactive-impulsive behaviour' is less once the young person has left full-time education. Similarly, there may be less expectation from key adults that treatment is still necessary since the context within which the behaviour is problematic is no longer relevant. These considerations highlight how the school system is implicated in identifying and referring young people with ADHD.

In those countries that draw on the DSM, it is often teachers who are the first to identify the condition, although again, there are national differences in the extent to which this occurs. For example, Malacrida (2004) indicates that at the time of her study, Canadian teachers were more likely to suggest a diagnosis of ADHD than British teachers (she does acknowledge that this is changing and that British teachers are increasingly likely to identify ADHD). One of the reasons Malacrida (2004) suggests for teachers' take-up of the medical label ADHD is that teachers have increasingly limited scope to discipline children and have limited options of managing disruptive behaviour within the classroom. She suggests that 'social control', such as temporary exclusions, is much more likely to be practised by British teachers.

A further possible reason for the increase in identification of ADHD within the school context is one put forward by Adams (2008) who suggests that results have become the prime focus of education. Education, he argues, is target driven and

situated within economically determinist assumptions of the post welfare era. Consequently, children are increasingly required to display certain classroom behaviours which lead to increased performance in exams. It is just these behaviours that are, arguably, the most problematic for children diagnosed with ADHD. Teachers, under pressure to attain certain targets, may be more likely to seek a medical explanation or solution for a child whose behaviour does not conform to classroom expectations. As Adams (2008) asserts a behavioural category such as ADHD does not necessarily reflect impairment but rather a socio-cultural and political action.

This position locates understanding and management of the problematic behaviour both within the classroom and at a wider societal level. This resonates with Rose's Foucauldian position (1999) which suggests that difference becomes visible within local institutional sites such as schools and is explained and managed through existing regimes of truth, technologies and expert knowledge that circulate within the societal domain. In particular, as Rose suggests, difference in children is identified and managed through the involvement of psychology and its normalising notions of children's development within sites such as the school, the clinic and indeed, the family.

Certainly, the advent of mass education provided an opportunity for the observation and normalisation of childhood behaviour by the so-called psy disciplines. One way of managing large numbers of individuals was by measuring and assessing test aptitudes, abilities and behaviours. Mass education and testing coincided with a rise in child development. Appropriate and normal stages of growth and development were charted and children fell increasingly under the gaze of psychologists and child experts. Psychological testing in the form of IQ tests meant that intellect could be managed. As Rose (1999) suggests the

statistical concept of normal distribution became the key way to visualise human variability.

Central to the construction of an 'object' (or category of 'being', as in the case of ADHD) is the emergence of problems within the 'operations of particular practices or institutional sites' (Rose, 1999:xi). Typically, it is within schools that individual childhood difference becomes visible. Indeed, the emergence of Still's 1902 category of the 'moral imbecile' to describe children with hyperactive behaviour coincided with the advent of compulsory schooling (Resnick, 1993). In describing 'normal' developmental stages, and normative standards and practices, developmental psychology constitutes both the normal and the 'not normal' child (Graham, 2006). Children, who lie 'outside' the norm, are discursively constructed as Other.

The psychological scrutiny of the school child is deeply implicated in the process of individualisation and this merges with 'the individualising/differentiating logic of the contemporary school' (Tait, 2001:100), which contributes to the production of categories of difference within the classroom situation. Adams (2008:113) points out that teachers are required to mediate contradictory policies of increased attainment and inclusion of pupils with special needs. Arguably, these two governmental policies support the practice of turning to a medical model if the behaviour of the child does not 'fit' with desired and conventional classroom conduct. The medical model locates the problem within the child, rather than within the context; it also requires specialist help and management in the form of child psychologists and development experts.

It is certainly true that there has been intensification in the number of classifications of difference within the classroom. Tait (2001) suggests that whereas in the early 20th century there were around eight classifications of

educational difference, there are currently over 300. Arguably, the discourse of inclusive education which permeates Anglophone education systems, not only enables the identification of pre-existing difference but also contributes to the emergence of difference within the school system. Graham (2008) debates whether inclusion as a concept 'discursively privileges notions of the pre-existing' status quo as it seeks to include the other into the existing system. As Graham (2008) points out practices which are performed in the name of inclusion, in fact strengthen the invisible centre; the normative centre around which all difference is positioned remains unnamed and **not**, therefore, subject to scrutiny. Graham further argues that in seeking to assimilate into a norm we are in danger of supporting 'the perceptions of disability (and difference) as an alien or exceptional condition.' (Graham, 2008:280)

Geographical factors

Adopting a cross-cultural perspective alerts us to how differently ADHD is understood in different cultures and how a medical understanding of ADHD may not be the only viable one. Mchoul and Rapley (2005) point out that ADHD is largely confined to Anglophone nations and, specifically, schools. In Korea for, example, teachers frame a child's challenging behaviour in terms of their ineffectiveness as teachers (Hong, 2008) rather than a problem located within the child. Danish teachers, on the other hand rather than seeking medical explanations for children's behaviour tend to seek explanations within the child's environment (Holst, 2008). This study also points out how reluctant Danish teachers are to suggest a diagnosis of ADHD claiming a lack of knowledge and confusion over its aetiology. Holst (2008) also comments on the relatively relaxed attitude of Danish teachers to the behaviour of young children within education. The diverse cultural approaches to ADHD suggest that 'a particular form of behaviour may be considered deviant in one society or culture but quite

acceptable in another' (Einarsdottir, 2008), again raising the question of ADHD as a real versus a constructed phenomenon.

In addition to cultural differences, Einarsdottir (2008) also suggests the influence of the socio-historic context, which she argues might account for the significant increase of ADHD diagnoses in Iceland. A rapid change from a rural to urban lifestyle and a period of intense industrialisation resulted in children not being able to play outside all day as they historically had. She points out that there have been significant changes in the education system in Iceland with longer school days and larger classes and she posits that these changing practices may have adverse effects on children with a predisposition to ADHD type behaviour.

However, although it is tempting to adopt a particularly relativist position in relation to these diverse cross-cultural interpretations of ADHD, as Singh (2008b:348) indicates, there is also cross cultural consensus that 'there exists a group of children whose impulsive and hyperactive behaviours are qualitatively different, and more severe, than other groups of children'. Indeed, there is debate around whether cross-cultural/geographical variability is truly significant. Despite cross-cultural variances in understandings of ADHD, Polanczyk *et al.* (2007) argue that, with the exception of significant variability in diagnostic rates between North America and both Africa and the Middle East, variability has been overemphasised in the literature and is explained primarily by the methodological characteristics of studies. However, it is clear that understandings of ADHD are embedded within cultural and historical contexts. Within those countries that embrace the medical classification of ADHD, identification of emergent and problematic behaviour within the classroom is enabled by the dominant discourses of normalising psychology and educational inclusivity.

Identification of ADHD type behaviour is also mediated through interaction at a micro level. As Singh (2008b:356) points out, social categories such as gender and class are components 'through which children's behaviour is perceived, evaluated and treated' and the emergence of an ADHD diagnosis is, therefore, contingent on both local perceptions and culturally available discourses.

ADHD and socio-economic status

The social environment of the child does not feature in the DMS – IV TR classification of ADHD despite it acknowledging that prevalence rates of ADHD can range between 3-5% depending on the setting. However, there are some indications that an ADHD diagnosis is more commonly applied to children from poorer backgrounds. Graham (2008) suggests that in both the US and Australia, ADHD diagnosis and prescription of medication are disproportionate amongst individuals from families with low income and high unemployment. Lee and Neuharth-Pritchett (2008) indicate that 9.7% of children living below the poverty line are subject to an ADHD diagnosis compared to only 6.9% of children from affluent households. Similarly, children from families where the parents are no longer together are also more likely to obtain an ADHD diagnosis. 12.8% of children who live with neither mother nor father have an ADHD diagnosis compared with 9.4% of children who live in female-headed households and 6.4 % of children who live with both parents (Lee and Neuharth-Pritchett, 2008). There are no comparative figures for the prevalence of ADHD in the UK. However, there is some similarity in the rates of incidence of mental health problems and disorders as provided by the Office for National Statistics (2005), which suggests that mental health disorders are more likely among children who are living in families where neither parent is working compared with those where both parents work (20% and 8% respectively) and amongst those children who are living in lone parent families compared with 2 parent families (16% and 7% respectively). Additionally, ADHD

certainly seems more prevalent amongst children from families who are experiencing or have experienced stress of some kind. Indeed, as Angela Southall highlights, the symptoms of ADHD are very similar to the symptoms which individuals present when they have 'been in a state of chronic stress for years' (Patrick, 2008), highlighting the possibility of a misdiagnosis of a medical condition.

ADHD and gender

There are significant differences in diagnostic rates amongst boys and girls. The ADHD diagnosis is far more likely to be applied to boys than to girls (Horton-Salway, 2011, 2012; Ohan and Visser, 2009; Lloyd and Norris, 2000). The DSM-IV TR (2000) suggests that the prevalence rate of ADHD is 3%-5% of schoolchildren and the ratio of boys to girls diagnosed with the disorder ranges from 4:1 to 9:1 'depending on the setting'. This gender imbalance in rates of diagnosis is not accounted for by neurobiological explanations (Bailey, 2010) and, again, this contributes to the fuzziness of the concept.

One line of argument contained within the literature is that boys have more overt symptoms of ADHD than girls (Quinn, 2005). In particular, an ADHD diagnosis for a boy is more likely to have a high co-morbidity with conditions such as conduct disorder or oppositional defiant disorder. However, girls with an ADHD diagnosis are more likely to develop internalising symptoms (Quinn, 2005) such as anxiety and depression. As a result of their externalising disruptive behaviour, boys are, it is argued, more likely to come to teachers' attention, and hence, be referred for diagnosis (Horton-Salway, 2012; Ohan and Visser, 2009). A second line of argument states that the disproportionate diagnosis of boys is a result of a perception by parents and teachers that intervention, specifically in relation to learning support within schools, is of more benefit to boys than it is to girls,

perhaps reflecting a cultural bias towards education being of higher importance to boys than to girls (Ohan and Visser, 2009). A third suggestion is that research into ADHD is disproportionately skewed in favour of boys, and that, consequently, clinician, parental and teacher knowledge of ADHD is constructed through texts in which boys' behaviour becomes visible, whilst girls' behaviour is rendered invisible (Bailey, 2009). Bailey suggests this is the legacy of a historic propensity to study problematic male populations. Certainly, the early 'history' of ADHD would support this: from Still's (1902) (boy) moral imbeciles, identified as 'backward' within the context of their school environment, to the identification of *encephalitis lethargica* in the 1920s in the post war male population (specifically within schools and institutions consisting of boys), through to Bradley's (1937) experimental testing of Benzedrine on young hospitalised boys. As Bailey says (2009:172), 'each advance in medical perspectives was based on the availability of a male problem population upon which to drive the *natural* science'.

The propensity of research into problem male populations is matched by an equally biased focus towards mothers. Indeed, much of the existing literature on ADHD consists of studies of problem boy and (problem) mother (Horton-Salway, 2011, 2012; Blum, 2007; Malacrida, 2001, 2004; Singh, 2004). Studies can be seen to reflect and, in so doing, to (re)produce the socio-cultural/historic repertoires of mother-blame (Bennett, 2007; Blum, 2007). It is within this context of mother-blame that diagnosis is sought mostly by women who are the 'primary instigators of a diagnosis' (Singh, 2008b:356) (further discussion of this will be given in Chapter 3).

However, again there are cross-cultural differences in maternal calls for diagnosis. Malacrida (2001) points out that in Canada, which has a higher rate of diagnosis than the UK, mothers are much more likely to resist classification of their sons'

behaviour, whereas in the UK, mothers are much more likely to seek out a diagnosis of ADHD and in fact, talk of professionals' reluctance to classify. This is supported by Norris and Lloyd's (2000) findings that British mothers express negative comments about medical professionals who resist giving their children a diagnosis of ADHD.

Fathers appear far less in the literature relating to ADHD (Horton-Salway, 2012; Gray, 2008). In relation to diagnosis, fathers are typically presented as being less likely to seek diagnosis (Singh, 2003). One of the key reasons suggested for this is that fathers identify with their sons' condition and consequently seek to normalise it (Conrad, 2006; Singh, 2003). For a fuller discussion of ADHD and gender, see Chapter 3.

Singh suggests that all of these factors impact on the variability in diagnostic rates of ADHD but are not necessarily implicated in the debate around the causes of ADHD.

2.4 The controversy around the causes of ADHD

Neurobiological accounts

The underlying causes of ADHD are not fully understood. However, scientific research continues to seek biological and genetic explanations (Remschmidt, 2005). Cooper (2001, 2008) suggests that research has typically concentrated on three areas of theoretical exploration: cognitive, neurobiological and genetic. In relation to cognitive factors, research which has focused on the impulsivity 'characteristic' of ADHD, has identified problems in four major areas of 'executive functions' (Bradley, 1997, cited in Cooper, 2001). These executive functions affect cognitive performance in areas relating to working memory, internalised speech, motivational appraisal (a system which regulates decision making based on the association of emotion and behavioural outcomes) and behavioural synthesis, an

ability to modify future behaviour based on assessment of previous behaviour outcomes (Cooper, 2001). These cognitive dysfunctions are understood to have an underlying neurobiological basis. Neurobiological explanations of ADHD include a malfunction of the central nervous system (Kean, 2005) and a dysfunction in the dopamine transmitter system, which interferes with concentration and attention (Singh, 2008a). Recent interest in neuroimaging, has implicated the involvement of frontostriatal abnormalities in the manifestation of ADHD type behaviour. Arguments that support a genetic basis for ADHD are grounded in research findings that claim there is a greater incidence of ADHD in identical twins than in non-identical twins, and among children and parents who are biologically related, than between children and parents who are not biologically related (Cooper, 2001, 2008; Remschmidt, 2005). Genetic explanations regularly appear within media representations of ADHD (Horton-Salway, 2011, 2012; Schmitz, Filippone and Edelman, 2003). Within the UK media, it is fathers, in particular, who are implicated in the genetic explanation for ADHD, which, as Horton-Salway (2012:7) suggests, 'has the effect of re-producing ADHD as a male phenomenon by implication, foregrounding boys as the natural recipients of inherited ADHD and fathers as passing it on.'

Biomedical versus social: A polarised debate

Biological and genetic explanations for ADHD have been subject to much scrutiny and criticism. Singh (2002b) and Cooper (2001) describe the influence of the anti-psychiatry movement in critiquing the validity of such categories as ADHD. In particular, they single out the work of Thomas Szasz, who suggested that mental illness is a metaphor (because there is no demonstrable biological pathology) for culturally disapproved thoughts, feelings and behaviours' (Singh, 2002b:362). Certainly, ADHD as a medical category remains controversial while there continues to be an absence of a valid clinical test for the condition, and ADHD

symptoms, it is argued, remain barely distinguishable from normal childhood behaviours (Singh, 2008a, Timimi and Taylor, 2004).

Singh suggests the anti-psychiatry movement was pivotal in informing intellectual and theoretical positions that aligned state mechanisms of social control with the medicalization of deviant behaviour and, in turn, hyperactivity (see Conrad, 2006). As Conrad (2006:4) states, 'medicine always functioned as an agent of social control, especially in attempting to normalise illness and return people to a functioning capacity in society'. This view is endorsed by child and adolescent psychiatrist Professor Sami Timimi, who suggests that increasing rates of diagnosis of ADHD reflect changes in society's tolerance for behaviour that does not conform to social or developmental norms (Timimi and Taylor, 2004). Timimi, in dialogue with Taylor, another child psychiatrist, who holds different views, queries whether ADHD is a cultural construct rather than a medical reality (Timimi and Taylor, 2004). He cites the absence of a medical test for ADHD, cultural differences in prevalence rates, high levels of co-morbidity of the disorder, and the relatively small sample sizes used in neuroimaging studies as reasons to doubt the veracity of ADHD as a biomedical entity. Rather, he considers external factors such as family breakdown, frenetic family life, school pressure, the breakdown of moral authority within the family, and even the competitive nature of the market economy as being detrimental to children's mental health (Timimi and Taylor, 2004).

As mentioned earlier, since the 1940s and 1950s there has been scepticism towards the neurological approach to ADHD. As well as the social factors considered by Timimi, other social explanations offered as a way of understanding the causes of ADHD include the over stimulation of modern life and the bombardment of children with fast and often frenetic visual and sensory

information through television and gaming (Rafalovich, 2008; DeGrandpre, 2000). Since the 1970s, literature linking behaviour and diet has received popular attention. In particular, reactions to artificial food additives (Rafalovich, 2008; Feingold, 1974) are said to produce hyperactivity in children. As Horton-Salway (2011:544) identifies, the 'toxic generation' is a common media representation of children and young people with an ADHD diagnosis.

In critiquing the biomedical model, it can be tempting to enter into a polarised debate about whether ADHD is a mythical or real category, and to take up the extreme relativist position that all medical categories, including ADHD, have no medical truth but are wholly socially created. Whilst expressing some reservations about the limitations of the biomedical focus on internal cognitive structures and its exclusion of individual and social context, Singh (2002b) and Cooper (2001, 2008) caution against dismissing biomedical explanations. Indeed, they argue that the existence of so much neurobiological evidence supports, at least, a partial, biomedical understanding of ADHD.

However, despite significant scientific interest and activity taking place to identify biological and genetic causes of ADHD, a solely biomedical approach to this highly complex disorder is also considered over simplistic. Increasingly, evidence suggests that genetic and environmental factors are both implicated in the production of mental health disorders such as ADHD (Singh, 2008a; Sonuga-Barke, 2005).

The biopsychosocial approach

Many ADHD researchers (Cooper, 2001, 2008; Gray, 2008; Sonuga-Barke, 2005; Singh, 2002b) call for a biopsychosocial approach, which integrates biological and socio-cultural aspects. Cooper's (2008) call for such an approach is premised on research that implicates a child's environment. In particular, he cites studies (e.g.

Nigg and Hinshaw, 1998) that suggest biological predispositions to ADHD are mediated by social and environmental factors such as parenting skills, disorderly home environments, marital or relationship discord maternal health and paternal personality factors. In positing a biopsychosocial approach, Cooper (2001, 2008) and Singh (2002b) call for a multimodal approach to treatment which incorporates medication with other forms of intervention, intervention that explicitly deals with environmental factors (although Singh is more reserved in her endorsement of treatment with stimulant medication). As Gray outlines in her thesis (2008), the biopsychosocial approach to ADHD is one that has been taken up by current health policy frameworks. NICE (2009) advocates a multimodal approach to treatment incorporating both pharmaceutical and psychological treatments. However, despite increasing calls for a multimodal approach, medication remains a significant method in the treatment of ADHD and contributes greatly to the controversy surrounding it.

2.5 The controversy of medication

Stimulant medication such as methylphenidate (Ritalin, Concerta and Equasym) and dexamfetamine (Dexedrine) is typically used to treat ADHD and it is the most common treatment within the USA (Rafalovich, 2008) and Australia and is officially recommended by NICE as a first-line treatment for adult ADHD in the UK (Moncrieff and Timimi, 2013; Schubert *et al.*, 2009). Recent years have witnessed a dramatic global increase in the prescription rates of these stimulants and NICE (2009:28) indicates that between the late 1970s and the late 1990s global prescription rates rose from 0.5 per 1000 children to more than 3 per 1000 in the late 1990s (Horton-Salway, 2012). With regards to the UK, NICE (2009) reports a marked increase in prescription rates since the 1990s. Frankel (2010) suggests prescriptions rose from 6000 in 1994 to 461,000 in 2007. As mentioned at the start

of this chapter, recent media attention suggests there has been a 50% increase in Ritalin prescription in the last six years, rising from 420,000 prescriptions in 2007 to 657,000 in 2012 (Donnelly, 2013; Meredith, 2013; Saul, 2013).

Controversy has surrounded the use of stimulant medication since it was first discovered to be effective for hyperactivity in the 1930s. As NICE (2009:231) indicate 'it is over 70 years since the serendipitous observation that stimulant drugs can improve hyperactive behaviour in children (Bradley, 1937)'. The use of the word 'serendipitous' points to the accidental nature of the discovery, which, in turn, contributes to its controversial status. Bradley noted that the use of Benzedrine on a group of thirty boys, hospitalised for a range of mental disorder diagnoses, produced remarkable improvements in their academic performance and a greater engagement with their surroundings. As Rafalovich (2008:71) states, 'Bradley's findings opened a new path in child neurology in which the effects of stimulants upon child behaviour attained an immediate interest'.

Issues of validity

As Conrad observes (2006), the treatment preceded the disorder. However, once the disorder emerged, then many scientists seeking neurological explanations for hyperactivity argued that the success of stimulant medication was proof of the disorder (see Singh, 2002b). Yet, there is evidence to indicate that stimulant medication has an equally positive effect on all children, improving concentration and energy levels (Graham, 2008; Singh, 2005; Timimi and Taylor, 2004). This is supported by evidence which reveals a developing local trade (and subsequent use) of Ritalin amongst young people at school or university (Poulin, 2007; Billington and Pomerantz, 2004; White, 2003) and its reported increased use as a 'smart drug' in the UK (Donnelly, 2013; Meredith, 2013; Saul, 2013). Concerns around the medical validity of pharmaceutical treatment appear frequently in the

critical literature around ADHD (Moncrieff and Timimi, 2013; Singh, 2008a). In particular, there is concern regarding the absence of longitudinal studies into the effectiveness of medication, an issue which, Moncrieff and Timimi (2013:59) argue is judiciously ignored in the NICE guidelines:

the guideline identified that drug trials have shown no long-term benefit in ADHD, but still recommended treatment with stimulant drugs for children with severe symptoms and for all adults claiming consensus for this position... [The guideline] demonstrates how contradictory data are managed so as not to jeopardise the currently predominant view that ADHD... [is a] valid and un-contentious medical... [condition] that should be treated with drugs.

We have already seen how pharmaceutical activity might be implicated with the significant global variability in prevalence rates; pharmaceutical activity is also implicated with issues of validity. Doubts around the validity of stimulant medication in the treatment of ADHD are fuelled by critiques which are sceptical of the role the pharmaceutical industry has played in promoting medicalization of certain childhood behaviour. Much of the literature points to the involvement and financial support of the pharmaceutical companies with parent support groups (Graham, 2008; Conrad, 2006, 2007; Lloyd and Norris, 1999; Billington and Pomerantz, 2004), and indicates the mutual financial benefit to both the drug companies and the parenting groups of such involvement. Conrad (2007) charts how, in the USA, the organisation Children and Adults with ADHD (CHADD) has been pivotal in expanding the categorisation of ADHD to include adults, and how this organisation has received considerable financial assistance from Ciba-Geigy (now Novartis), a leading manufacturer of Ritalin. As Conrad (2007) suggests, by

redefining ADHD as a lifetime disorder, the potential exists to keep children and adults on medication indefinitely.

Doubts around validity and financial reward inevitably raise considerations of ethics and morality with regard to the issue of medication. The pharmaceutical industry is further implicated with issues of morality through several litigation cases of class action taken by individuals against the industry, specifically, in relation to the physical harm said to have been caused by using the medication (Graham, 2008).

Physical harm

Concern around the potential physical harm caused by taking stimulant medication is well documented in the literature (Meredith, 2013; Frankel, 2010; Graham, 2008; Rafalovich, 2008; Billington and Pomerantz, 2004). The possible side effects identified include psychotic reactions, the development of tics, an increased tendency to self-harm and a suppression of appetite leading to reduced growth rates.

Uncertainty and, perhaps, unease around long-term medication of children is suggested by literature which reports clinicians' ambivalence towards the effects of medication and which reveals how the 'perceived risk of harming children' is managed through talk of 'medication holidays' (Rafalovich, 2005:316). Similarly, parents also reveal an uncertainty around medication, particularly, at weekends and holidays (Singh, 2004) and they too, talk of medication breaks (Neophytou and Webber, 2005; Singh, 2005) or describe how they assume responsibility for the monitoring and 'fine-tuning' of their child's medication (Taylor *et al.*, 2006; Litt, 2004).

Moral harm

In addition to the possible physical dangers of taking stimulant medication, there is also discussion within the literature of the moral repercussions of taking drugs to control behaviour. Concern is expressed over the possible addictive nature of these drugs, and the subsequent issues of stigma, autonomy and dependence that this raises for children (Singh, 2008a; Singh, 2005; Rafalovich, 2005).

Billington and Pomerantz (2004) suggest the medication reduces opportunities for children to practise the skills necessary for the development of self-control, responsibility and self-regulation.

Despite these concerns over the physical and moral harm caused to children, Singh (2008a) queries whether this anxiety is a reflection of contemporary, socio-cultural (Western) conceptualisations of childhood. As she argues, our understanding of childhood is that it is a time (and state) of innocence. Current ideology positions the child as vulnerable and in need of protection, and, consequently, society is vigilant to the potential dangers from which the child is considered to be at risk. This conceptualisation of childhood might, Singh argues, prejudice an open debate about the benefits of medication to the child. Indeed, there is evidence that suggests children express an acceptance of, if not desire for, (continued) medication (Singh, 2008a), and report moderate benefits to academic, social and concentration skills (Billington and Pomerantz, 2004).

Parents and medication

Parents are clearly implicated in contemporary understandings of the child as vulnerable, innocent and in need of protection. Within current neo-liberal ideology (see Chapter 3), parents are understood to (want to) assume prime responsibility for the care, protection and well-being of the child. The issue of (parental) responsibility is a significant one in relation to the prescribing of stimulant

medication to control anti-social behaviour in children. Much of the existing literature suggests that parents seek medicalization for their children as a way of absolving themselves of responsibility for disciplining their children (Horton-Salway, 2011, 2012; Rafalovich, 2005; Singh, 2005). Other literature queries who actually benefits from medication, suggesting that it is of more benefit to parents (and teachers) than it is to children (Graham, 2008). Finally, some literature demonstrates how parents are portrayed as abusive in some media accounts of parental 'drugging' of their children (see Horton-Salway, 2011:542).

The moral alignment of parents with the ADHD category is further considered in the final section of this chapter, along with a formulation of ADHD as a moral category.

2.6 ADHD: A moral category

So far, this chapter has examined how ADHD has come to be a contested and controversial category. It has argued that changing historic definitions have contributed to the existing vagueness around the category, but that a pervasive concern with ADHD as a moral category has threaded itself throughout these shifting understandings and categorisations, in particular, through changing formulations of hyperactive and impulsive behaviour as a sign of social deviance, immoral weakness and criminality. Medical, psychological and social research has sought, respectively, to discover the organic, cognitive/emotional and environmental foundations for this lapse of morality. As Horton-Salway (2011) points out, the discourse of morality continues to be woven throughout current literature relating to ADHD (Schubert *et al.* 2009; Rafalovich, 2008; Klasen and Goodman, 2000).

The chapter has also argued that controversy around the category remains due to issues relating to diagnosis, the causes of ADHD and medication. The

controversial and contested status of the category further implicates ADHD as a moral category. Controversial categories are, by their very nature, understood in different and contrary ways; these ways of thinking about and conceptualising such categories are created by processes of history which inform our contemporary ideology (Billig *et al.*, 1988). As outlined at the beginning of this chapter, dilemmas around organic versus environmental aetiology have influenced the debate around the category ADHD. The availability of contrary themes around a topic informs our (at a societal and individual level) thinking around a topic but, these contrary themes are also employed by us in our everyday discourse. In talking about controversial social phenomenon such as ADHD, we draw upon the linguistic resources, or interpretative repertoires (Edley, 2001a; Potter and Wetherell, 1987; Gilbert and Mulkay, 1984), made available by each of the contrary themes and formulations of ADHD. Interpretative repertoires are described as 'the building blocks used for manufacturing versions of actions, self and social structures in talk ... resources for making evaluations, constructing factual versions and performing particular actions' (Wetherell and Potter 1992:90). As Billig *et al.* suggest the availability of competing linguistic versions of a phenomenon means that the selection of a particular version over another expresses a moral evaluation. This is particularly true for a category such as ADHD whose aetiology is so strongly contested.

Biological versus psychosocial repertoires of ADHD

As outlined earlier, there are three competing versions as to the 'truth' about the causes of ADHD. First, that it has an organic provenance. Second, that it is socially produced. Third, that it is the combination of environmental factors and a genetic predisposition to the disorder. These different versions of the causes of ADHD perform distinct moral work, and make relevant very different subject positions (identities made relevant by the specific ways of talking) for the

individuals implicated by the categorisation (see Horton-Salway, 2011; Edley, 2001a). Horton-Salway's study of the UK media (2011) indicated that the two main repertoires presented were the biological and psychosocial ones and she outlines how children and their parents are positioned within these different repertoires. Within the biological repertoire, the behaviour of children with ADHD is disruptive and problematic. However, crucially, this is a symptom of their neurobiological atypicality and, consequently, children, and their parents, are not to be blamed or held responsible for this behaviour. As Gray (2008) suggests, parents are positioned as external to the child's difficulties. Within a medical repertoire, it is not problematic for parents to seek medication for their children, as it is interpreted as acting in their best interests. Both child and parents are positioned as in need of support and intervention, in particular, medical and expert involvement in the life of the family. Certainly, existing literature suggests that parents, and, specifically, mothers seek medical diagnosis of their children's behaviour (Bennett, 2007; Singh, 2004; Malacrida, 2001; Norris and Lloyd, 2000).

Within the psychosocial repertoire, a child's unruly behaviour is represented as being socially deviant, for which environmental, social and cultural explanations are sought. Typically media representations of ADHD invoke modern life as a contributory factor in children's disruptive behaviour (Horton-Salway, 2011).

Children's lives are portrayed as being adversely affected by excessive use of TV and computer games, excessive consumption of fizzy drinks and additives in food, and by a decline in discipline and social control. All of these factors are seen to contribute to children's unruly behaviour. As it is parents who typically mediate between the wider social environment and their children's lives, they are held responsible for their children's behaviour. Consequently, as ADHD is not understood medically, then within this repertoire it is problematic for parents to seek a medical diagnosis. Medication is represented as being overprescribed, and

an extreme and inappropriate solution which, at times, is represented as abusive (Horton-Salway, 2011). Instead of medical intervention, within this repertoire, the behaviour of these 'undisciplined' children can be managed by intervention at a family level, such as through parenting classes.

The subject positions made available through this repertoire are very distinct from those made available within the biological repertoire. The child is represented as a 'normal' but socially deviant child in need of discipline. As parents are held, at least partially, responsible for this lack of discipline, they are positioned as ineffective and unskilled for the job of 'parent' (Horton-Salway, 2011). They are represented as lacking in discipline. This is in contrast to parents of the past, who are represented as having a disciplinary presence (Horton-Salway, 2011). The contrast with the past also makes relevant certain gendered subject positions: In particular, the traditional association of discipline with effective fathering. Within this repertoire, parents who seek to medicalise their child's behaviour are represented as self-interested, and even abusive, as discussed in the section on medication above.

However, despite the quite substantial disparities in diagnostic rates, persuasive arguments that posit the contributory role of the environment, and the fact that there is 'no neurological, metabolic or attentional tests to confirm the existence of ADHD' (Stolzer, 2009), the DSM's medical classification of ADHD presents itself as 'the truth' and the everyday understanding of ADHD within many cultures is that it is a valid neurological disorder.

2.7 Summary

This chapter has described the contested and controversial status of ADHD as a medical category and has shown how, historically, understandings of the disorder have been imbued with a moral discourse. The chapter argues that the discourse

of morality prevails within wider social discourse relating to ADHD, in particular implicating parents and parenting styles in the production of 'disordered' children. The themes of parents, parenting and ADHD are further explored in the next chapter.

Chapter 3 Parents and ADHD

3.1 Why Parents?

Through the eyes of their educators, clinicians, and parents, the ADHD child's world requires regulation to promote the "management" of his/her disorder. Invariably, the active agents in this management are the authority figures surrounding ADHD children.

(Rafalovich, 2008:151)

As Rafalovich indicates, the most significant authority figures to undertake the management of ADHD are parents. Parents are, invariably, involved in diagnosis (often the ones to seek diagnosis), in mediating between schools, professional organisations, medical experts, support groups and even extended families. Parents are implicated in the monitoring and management of their child's behaviour pre and post diagnosis, and, crucially, parents are given responsibility for administering their child's medication. Rafalovich's study (2001a) of the literature directed at parents of children with ADHD highlights the expectation that is placed on the domestic sphere to regulate the behaviour of these children.

As with parents of children with physical disabilities, parents of children with ADHD take on an advocacy role for their children, to enable them to access the services to which they are entitled (Shakespeare, 2006). For these reasons, as Singh (2002a:599) argues, it is legitimate that parents should be included 'in the scope of diagnosis and treatment' (and presumably research).

Klasen and Goodman (2000) also suggest that research into the experiences of parents of children with ADHD is important with regard to parental engagement and take-up of healthcare resources. As they suggest, clashes and differences in

viewpoint between parents and professionals can result in a reduced take-up of resources to which the child with the ADHD diagnosis is entitled.

Parents are further linked to ADHD within dominant discourses. For example, media representations of ADHD often suggest that the symptomatic behaviours of the condition are mistakenly interpreted within a biological/medical framework and are, in fact, nothing more than poor behaviour (see Horton-Salway, 2011). In turn, poor behaviour in children is inextricably linked to poor or irresponsible parenting. These media representations are indicative of a prevalent understanding which aligns bad parenting with ADHD and, consequently, places parents of children with ADHD at the centre of a highly moralised debate. This thesis will explore how parents manage this moral positioning.

Mothers and fathers

Although in the preceding paragraph the word 'parent' is used as a gender neutral term to refer to both and/or either mothers and fathers, it should be acknowledged that 'there remains an outstanding stability in mothers' *responsibility* for children and for domestic and community life' (Doucet, 2006:6). Consequently, many of the 'parenting' practices identified above (such as mediating between schools and medical professionals), are typically undertaken by mothers. This is discussed and exemplified in more detail throughout the chapter.

A further consequence of these gendered caregiving practices is that mothers are foregrounded in the literature and fathers are significant by their absence. Indeed, existing literature relating to parents of children with disabilities identifies fathers as 'hard to reach', 'the invisible parent' and the 'peripheral parent' (Carpenter and Towers, 2008:118). Therefore, the current research study aims to give equal focus to fathers' talk of their experiences.

From the general to the specific: Parents and parents of children with ADHD

Despite being members of the general category of 'parent', in singling out parents of children with an ADHD diagnosis as the subject of a research study, it is clear that such parents are positioned by the research as different and 'special' in some way. As Billig (1996) suggests, through processes of categorisation (the participants belong to the general category of parent) and particularisation (they are parents of children with ADHD), specific instances (of categories) are thus distinguished and split from the category in order to perform rhetorical work. This literature review adopts this discursive technique to construct an argument that parents of ADHD children are subject to the same social and cultural narratives that position all parents, but that through being the parents of a child with ADHD, they are also positioned differently. It will first examine literature that relates to the broad category of parent. Then it will consider the literature on parenting 'atypical' children (whether in terms of physical or behavioural difference). Finally, it will discuss existing research on the specific category of parents of ADHD children.

3.2 Wider debates around parenting

As Harden (2005) argues, parents' caregiving narratives are 'best understood within the context of wider sociological debates around the nature of parenting' (2005:352). Such debates take place within the historical context of late modernity (Giddens, 1991), which has witnessed an increased mistrust of expertise, and, crucially, a shift in responsibility for social support and welfare from the public to the private sphere. Within such a context, care for children has become the private responsibility of parents, and contemporary debates about parenting construct childhood as a 'socialisation project' (Harden, 2005), for which parents are held accountable. The main duty of parents is to produce a socialised, healthy and productive child (Harden, 2005) and to assume responsibility for their children's

anticipated futures (Backett-Milburn and Harden, 2004). Parents are positioned, and position themselves, as responsible for achieving successful outcomes for their children, and so, inevitably, if children are unsuccessful or deviant in any way, then parents are held responsible for that too. Harden (2005) identifies the 'parent deficit' account, which constructs parents as causally responsible for their children's anti-social behaviour. This view is supported by more recent literature which points out the prevailing neo-liberal discourses of 'responsibilisation' (Allen and Taylor, 2012; Barnes and Power, 2012; De Benedictis, 2012; Gillies, 2005) and its emphasis on the centrality of 'good' parenting to the production of 'good' citizens. The concept of responsibilisation is one theorised by Rose (1999) and emerges from Foucauld's theory of governmentality (see, Osaka, 2007; Lemke, 2002; Rose, 1999). As Lemke (2002:51) states, governmentality 'links technologies of the self with technologies of domination, the constitution of the subject to the formation of the state'. Central to both concepts is the "autonomous" individual's capacity for self-control and how this is linked to forms of political rule' (Lemke, 2002:52). As Rose argues, recent history has seen the merging of the private/public sphere, and increasingly, the family has become the key 'mechanism for social control' (see Rose, 1999:129). Self-governance and self-control are achieved through the discourse (or technologies) of responsibilisation. The duty of each family is to civilise themselves for the benefit of the wider community.

As De Benedictis suggests, current political discourse constructs strict formulations of what constitutes good parenting; with, specifically, an emphasis on marriage, stability and the presence of an authoritative father. Within this body of literature, parents with troublesome children do not fulfil the 'strict definitions of the norm of who the 'good' parent citizen can be' (De Benedictis, 2012:8) and are thus demonised and blamed for their children's transgressions. Children's transgressive

behaviour is seen as resulting from parental irresponsibility. Although children's behaviour can be condemned, contemporary understandings of childhood (mainly) construct children as innocent and lacking in moral agency. Therefore, moral accountability for children's troublesome behaviour lies with their parents, and places their moral identities at stake. Moral identity was identified as a concern of parents in a study by Ribbens McCarthy, Edwards and Gillies (2000). It manifested itself in parents' concern to demonstrate responsibility for their children's actions and 'their acknowledgement of their moral obligations through having tried to control their charges' (Ribbens McCarthy *et al.*, 2000:788). The key to being a 'moral agent', Ribbens McCarthy *et al.* argue, is being seen not to be wilfully avoiding responsibility.

Although there is an emphasis in current ideology and discourse on the importance of stable family environments, and a 'strong' father presence (Allen and Taylor, 2012; Barnes and Power, 2012; De Benedictis, 2012; Gillies, 2005), it is, undoubtedly, mothers who traditionally have been (and still are) held most responsible for their family's behaviour. This is evidenced by the significant body of work that illustrates and acknowledges the gendered nature of caregiving, and responsibility for children (Bennett, 2007; Doucet, 2006; Gillies, 2005; Harden, 2005; Litt, 2004).

Gendered care-giving

The Western, culturally specific, family ideal promoted throughout the 20th Century by psychoanalysts such as Bowlby and Winnicott, is the 'gendered binary opposition between a public, masculine sphere and a feminine, private sphere' (Weusten, 2011:57).

Mothers, in particular, are held responsible for their children's well-being, and future outcomes; they are positioned as intrinsic to the production of valuable,

future citizens (Weusten, 2011; Blum, 2007; McKeever and Miller, 2004). This discourse of maternal responsibility inevitably merges into a discourse of blame. If children deviate from social and/or developmental norms, then it is mothers who are, ultimately, held responsible, or blamed. Historically, maternal behaviours have been held up for scrutiny and constructed as a cause for their children's deviance. Constructs such as 'the psychogenic mother' and the 'refrigerator mother' have been blamed for a range of medical conditions or social ills, such as autism and schizophrenia, (Weusten, 2011; Berman and Wilson, 2009; Blum, 2007; Singh, 2002a) and it is within this cultural context of mother-blame (Malacrida, 2001) that mothers' care-giving practices are situated (mother-blame has a well-documented association with ADHD, and will be examined later in this chapter).

Fathers' caregiving practices are situated within different cultural understandings. The traditional positioning of fathers within the public sphere (as opposed to mothers' positioning within the private sphere) co-exists with contemporary notions of the 'new' father. The 'new father' subject position emerged in the 90s and coincided with an increased interest in fatherhood at the level of public policy (see Featherstone, 2009; Robb, 2004a). Government policy since the 90s has emphasised the importance of fathers' active involvement in family life. 'Good' fathers are constructed as being involved fathers. However, meanings of what it is to be an 'involved' father shift depending on prevalent ideology and contemporary repertoires. On the one hand, the 'involved father' invokes a very 'hands on', practical care-giving approach to parenting. On the other hand, it can 'merely' invoke a paternal 'presence' in family life; an engagement with the private, family sphere. The 'involved' father construct has, arguably, emerged from two separate and ideologically distinct repertoires. As Yarwood (2011) points out, 'the current political, economic and social climate aim to construct a gender neutral dual earner family', which, arguably, positions fathers inside the home alongside

mothers, as much as it positions mothers outside the home alongside fathers. This perhaps makes available the subject position of the nurturing, 'hands-on' 'new' father more available. Alternatively, however, the active involvement of fathers in family life has also been promoted by such social constructs as the 'absent' or 'dangerous' father; that is, a father who, respectively, either neglects or abuses his child (see Robb 2004a; Lupton and Barclay, 1997). As mentioned earlier, this latter subject position is one that is made increasingly available within contemporary neoliberal discourse. The ideologically charged 'absent father' subject position is currently aligned with notions of a lack of parental authority and/or responsibility within the family. The association of authority and discipline with fathers is by no means a new one, and is one that fathers made relevant in their talk in Lupton and Barclay's study of 1997, in which they drew on the subject position of guardian of their family and presented themselves as 'holding' the discipline in the family.

As Lupton and Barclay (1997) argue, notions of fatherhood and motherhood are interrelated, with each category drawing meaning from opposition against as well as alignment with the other. The construction of meanings around identity are relational and constitutive (Burr, 2003; Shotter, 1997). The identities (or subject positions) that are made discursively relevant by and for mothers, also work to position fathers, and vice-versa (for detailed discussion of subject positions, see Chapter 4). For example, the identity of the 'professional' mother has surfaced increasingly in recent years, and this, whilst obviously positioning mothers, must necessarily have a positioning effect on fathers. The traditional power dynamic of families, with the father as the chief breadwinner, has shifted and, arguably, as Featherstone (2009) suggests, this has resulted in fathers seeking to enhance their paternal role. However, the powerful, biological based accounts of caregiving that permeated throughout the 20th Century, and prevail today, claim that mothers

are instinctively better at providing the care and emotional needs of their children (Doucet, 2006; Harden, 2005; Litt, 2004; Lupton and Barclay, 1997). As Doucet (2006) suggests, the 'symbolic power of mothering' is such that women are reluctant to give up this area of power and expertise and, consequently, fathers are, at times, excluded from taking on the care and emotional responsibility of their children. Indeed, research suggests that fathers' involvement in childcare is contingent upon their partners' (the mothers) acquiescence. Both Doucet (2006) and Featherstone (2009) talk of the 'maternal gatekeeping' role mothers assume in mediating fathers' involvement and engagement with their children. However, as Doucet suggests, this positioning is not one that is generally challenged by fathers. As Lupton and Barclay argue (1997:132), unlike women's subject position as a 'good' mother, 'men's subject position as a 'good' father appears not to depend to quite the same extent upon demonstrating expertise in and dedication to the care of one's children'. Instead, fathers have recourse to alternative repertoires (linguistic resources) and subject positions in the construction of themselves as 'good' fathers. The good father identity has been associated with repertoires of 'provision' and earning income to support the family (Yarwood, 2011; Riley, 2003; Ranson, 2001; Lupton and Barclay, 1997) as well as repertoires of 'protection' of their vulnerable and dependent children (Lupton and Barclay, 1997). The subject position of the new, nurturing/involved father provides a distinct representation of what constitutes 'good' fathering from the one offered by the subject position of the 'providing' father. Concepts of the 'good' father reflect not only our own times, but also the history with which these concepts are infused. These potentially contradictory notions suggest the dilemmatic nature of common-sense understandings of what constitutes good fathering. The presence of such *ideological dilemmas* in common-sense understandings arise from the existence of multiple discourses that can be contradictory (see Billig, Condor, Edwards, Gane,

Middleton and Radley, 1988). The tension between these contrary linguistic repertoires is identified by Ransom (2001) who suggests that, for fathers, the tension between breadwinner and new father plays out as a tension between work and family. However, other researchers suggest that traditional notions of masculinity are not necessarily counterposed to the more recent discourses of the involved and caring father (Henwood and Proctor 2003).

According to Billig *et al.* (1988), the existence of contrary themes within ideology, in this case contrary themes of what constitutes 'good' fathering, necessitates that individuals 'think and struggle with aspects of ideology', that they are not 'blinded bearers of a received ideological tradition' (1988:2). Certainly as a conclusion to this section on gendered care-giving, it is important to note the flexible nature of parenting identities. As Featherstone (2009) and Yarwood (2011) suggest, fathering identities (and clearly, this also applies to mothering identities) are not fixed, but shift and adapt as they intersect with other identities, and as they move from one context to another. Parents occupy multiple social positions, which involve particular 'interaction, negotiation...and the taking of a stance in interactions' (Visick, 2009).

A distinct position occupied by some parents is being the parent of a developmentally, 'atypical' child (a child, for example, whose cognitive, social and/or physical development differs from normative definitions of child development). The following section of this chapter examines the literature around parenting such children. Although this literature does not necessarily relate specifically to parenting a child with ADHD, there are thematic similarities between the broader category (parents of 'atypical' children) and the particular category (parents of children with ADHD).

3.3 Parenting the 'dangerous' child

Although current political and social discourses increasingly emphasise parental responsibility for children's healthy and productive outcomes, this is not a new phenomenon, especially with regard to 'troublesome' children. Rose (1999) charts the emergence of the 'dangerous' child in the 19th century and the subsequent emergence of social regulation as a result of the 'threat' these children posed to the future of the welfare state. As Rose (1999) says, the family (and mothers in particular) was to 'play a crucial role in regulating the behaviour of its members' (1999:129). The self-regulation and self-governance of family life, is accomplished, Rose argues, through the role of expertise. Rose (1999) charts the influence in the 19th Century of philanthropy and medicine and how 'medico-hygienic expertise began to elaborate a set of doctrines concerning the conditions for rearing healthy children' and how this expertise weaved its way into institutional sites such as schools, the courts and the clinics; ultimately, finding its way to the heart of the family. In producing a set of doctrines relating to the conditions for rearing healthy children, then, of course, notions of normality/abnormality emerge, as well as notions of the 'morally good' and 'morally deficient' family. As Rose suggests, normality is 'not an observation but a valuation' (1999:133); a moral judgement - an ideal to be attained through expert guidance and regulation. Increasingly since the 20th century, the expert knowledge that dominates our understanding of what constitute normal/abnormal children comes from the, so-called, 'psy' disciplines, specifically, psychology and, to a lesser extent, psychoanalysis (Singh, 2002a; Rose, 1999; Cohen, 1983). It is this scientific (psychological) knowledge which permeates the domestic sphere and which informs common sense understandings of what is normal and abnormal behaviour, and by association, what is moral and morally deficient behaviour.

Contemporary regulation of family life comes in the form of the ever increasing professionalisation of childrearing practices. Contemporary (UK) government discourse of 'good' parenting depicts it not as an 'intimate relationship, but as an occupation requiring particular knowledge and skills' (Gillies, 2005:77). Advice and guidance are typically disseminated through parenting books, manuals, television programmes and parenting classes. As Gillies (2005) points out, interventions are framed within a discourse of parenting support but, in fact, are infused with moral judgement as the emphasis of these interventions is on regulating and controlling the behaviour of marginalised families. Gillies emphasises the class dimension to these dominant notions of 'good' (middle class) and 'deficit' (working class) parenting. However, due to the socially 'troublesome' actions of children with ADHD, these class-biased, moral evaluations of what constitutes effective or 'good' parenting also resonate with families with children with an ADHD diagnosis (see Barnes and Power, 2012).

As a recent article in the Guardian suggests, the proliferation of so much parenting advice is indicative of a moral panic over parenting 'that feeds into the narrative of "broken Britain", in which "faulty" parenting is the cause of everything from obesity to educational failure and even divorce.' (Karpf, 2013). This positioning of parents as responsible for their 'faulty' children is evidenced by a search through contemporary developmental psychology journals which showcase psychological investigations of neurodiverse children (such as children with ADHD and Autism) and their families. Typical research includes a comparative study of parental involvement in children's learning where the parenting practices of parents of children with ADHD are compared with those of parents who do not have an ADHD diagnosis (Rogers, Weiner, Martin and Tannock, 2009). Another study examines the 'qualities' (such as warmth and responsiveness) of parents of boys with hyperactivity (Keown, 2011). These studies signal how the psy disciplines

(Rose, 1999) are both fed by and feed into the prevailing discourse; that there is, at best, an association between parenting practices and the outcomes for neurodiverse children, and at worst, a cause/effect relationship (see Keown, 2011; Rogers *et al.*, 2009).

The moral threat of difference

As Rose describes, children's successful cognitive, physical and/or social development has historically been interpreted within a moral framework. Existing literature highlights how developmental difference, or 'deviance', is constructed as a moral threat. Children who are deemed to be out of control are constructed as dangerous and as a 'threat to the moral order of society' (Ryan, 2006:294). This in turn implicates parents, specifically, mothers. Mothers perceive themselves to be judged not to be good mothers because they do not have good children (Austin and Carpenter, 2008). This has particular resonance with regard to mothers of children with an ADHD diagnosis as the behaviour of these children is 'disorderly, disorganised and disruptive' (Austin and Carpenter, 2008:378). However, maternal blame is not only directed at mothers of children with an ADHD diagnosis.

McKeever and Miller (2004) contend that 'mothers are often implicated in, and considered responsible for, their [children's] disabilities or illnesses' (2004:1182).

Courtesy stigma

Resonating with Goffman's concept of courtesy stigma (1990), contemporary research indicates that parents, but mothers in particular, of troublesome, deviant children share in their children's stigma and marginalisation (Harden, 2005; McKeever and Miller, 2004; Gray, 2002a, 2002b). It is significant that much contemporary research of parenting and troublesome (in its broadest sense, including 'atypical') children indicates that parents consistently report experiencing judgement and scrutiny with regard to their parenting practices from professionals,

family and friends (Berman and Wilson, 2009; Ryan, 2006; Harden, 2005; Todd and Jones, 2003). In particular, these feelings of 'felt stigma' (Goffman, 1990) are experienced in public spaces and situations (Ryan, 2006; Gray, 2000b), where 'the parents' competence is most likely to be judged and where the presence of a disabled (*sic*) child threatens the ability of parents to affect a presentation of family normality' (Gray, 2000b:740). Parental accounts of the effects of such scrutiny describe feelings of isolation and being unable to participate fully in social activities (Berman and Wilson, 2009; Gray, 2000b). Gray (2000b) and Harden (2005) both describe how parents selectively disclose information about their child's disability/mental health condition to those friends who would 'understand', as a way of normalising public life. The 'stigma' of their child's condition is perceived as being a reflection of their parenting; and it is significant that parents within this body of literature are shown to do much work to construct their own moral accountability as parents of 'atypical' children.

Moral accountability: coping, advocacy and compliance

Moral accountability is accomplished in different ways. Baruch's study of parents of children with physical disabilities (1981) revealed how parents oriented to understandings of parental responsibility, and, how they care to present themselves as morally adequate parents (see Silverman, 1985). In other studies, parents 'offer' their 'non-deviant' children as evidence of their parenting skills to raise 'normal' children, as well as evidence of their own moral worth (McKeever and Miller, 2004). Crucially, parents construct their moral accountability by accepting and engaging with their child's condition (Harden, 2005; Gray, 2000b). Acceptance, and advocacy is, as Harden suggests, a self-presentation of good parenting (Harden, 2005). Parents are often pivotal in urging medical recognition and diagnosis of their children's condition, and this, Harden suggests is parents fulfilling 'the most basic moral imperative of parental caregiving' (2005:358).

Parental acceptance of their child's *medical* condition is bound up with culturally available notions of parental responsibility and stoicism. Certainly, within this body of literature there are many accounts of parents coping with, and managing, their child's condition. Parents have a moral responsibility to cope; not coping would be an indicator of moral failure. Parents (mothers) present themselves as morally responsible through repertoires of 'trying one's best' for their child; typically, parents accomplish this by demonstrating expertise and knowledge about their child's condition, and through the assumption of advocacy roles. Existing literature is full of descriptions of mothers' competence. Competence is constructed through accounts of how mothers successfully mediate the social worlds on behalf of their children, guiding them to optimal psychological, physical and social development (Ryan, 2006; McKeever and Miller, 2004). Engaged, and 'good' parenting is demonstrated through accounts of knowledge, expertise and advocacy, in particular, where mothers take up a proactive role to demand access to health and educational resources on behalf of their children (Litt, 2004; McKeever and Miller, 2004; Todd and Jones, 2003). However, the take-up of an advocate role by parents is also a risky one. Proactive parenting can lead to confrontation with the professionals, and the literature indicates that parents (mothers) are sometimes described as being provocative and conflictual (McKeever and Miller, 2004). Clearly this has implications for accounts of good mothering. On the one hand, good mothers are those who agitate and demand for their children. On the other hand, mothers who assume a proactive role which is resistant to health care professionals are constructed as difficult and even pathological (Berman and Wilson, 2009).

The literature reveals that one way mothers negotiate this positioning is by assuming a compliance, or acquiescence, within certain medical and professional contexts (Berman and Wilson, 2009; Austin and Carpenter, 2008; McKeever, and

Miller, 2004; Malacrida, 2001). However, this compliant subject position that mothers, at times, make relevant may be understood as a form of resistance, in which mothers are working to validate their own positions within the hierarchical professional/lay relationship. As Berman and Wilson state (2009:450) a compliant subject position may be 'purposely adopted by some parents as a strategy to gain assistance for their child'. Their study was situated within a New England children's hospital and focused on intake workers' initial assessments of mothers of children 'with exceptionalities' (2009:445). Their findings revealed that a 'compliant' parent was constructed as a 'good' parent, and, therefore, more deserving of support and resources.

3.4 Parenting the ADHD child

Several of the above themes appear in the literature relating specifically to parents of children with ADHD, which is the focus of the next section. However, the particularity of ADHD, which arises from it being a strongly contested category, is such that it merits a distinct research focus of its own. As discussed in the previous chapter, there are competing explanations, or repertoires, of what it actually is. The prevailing biological and psychosocial repertoires make available very different subject positions for the child with the diagnosis, and for the parents too (Singh, 2004). If drawing on the biological repertoire, then parents can be positioned as the parents of a troublesome but 'sick' child in need of medical care and attention. If drawing on the psychosocial repertoire, then parents can be positioned as the parents of a troublesome but 'normally naughty' child, quite probably in need of some strong discipline. This clearly has an impact on the construction of subjects and identities and this is revealed within the existing literature.

The gendered nature of the ADHD phenomenon is reflected in both the media and the research literature (see Horton-Salway, 2011, 2012; Gray, 2008; Singh, 2002a, 2004). As Horton-Salway (2012:12) says of media representation, 'ADHD is represented as a predominantly male phenomenon with the focus on boys and men. However, stories referring to fathers are rare while stories representing mothers are more common'. This pattern tends to be reproduced in the literature with a research bias towards mothers and their sons, specifically, problem boys and problematic mothers (Horton-Salway, 2012; Singh, 2004,). Much of the literature refers to sons/boys rather than daughters/girls or even to the generic category of 'children', and this is reproduced within the following analysis of the existing literature, which first examines the literature relating to mothers and ADHD and then examines the literature relating to fathers and ADHD.

3.5 Mothers and ADHD

As already outlined in this chapter, one probable reason for the foregrounding of mothers in the literature around ADHD is the gendered nature of care-giving. As the literature suggests, it is mothers who assume medical responsibility for their children (and families) (Seymour-Smith and Wetherell, 2006) and, most typically, it is mothers who have most dealings with experts regarding their children.

Resonating with the wider literature on parenting and moral responsibility (see Ribbens McCarthy *et al.*, 2000), the accounts of mothers of children with ADHD orient to themes of responsibility, self-sacrifice and putting their children first (Austin and Carpenter, 2008; Bull and Whelan, 2006; Singh, 2004). A further reason for mothers' foregrounding in the literature is the historical implication of mothers in their children's disorders (Singh, 2002a; Rose, 1999). Both psychological and popular discourse suggests good mothering produces good children. Consequently, mothers are often judged in relation to their children's

behaviour and are blamed for it if it is not acceptable. As Caplan (1989, cited in Malacrida, 2001:145) says, the 'measure of a good mother is a perfect child.' An ADHD child is far from the normalised version of a perfect child. Indeed, the literature seems to indicate that on presentation of a child with a possible ADHD diagnosis to medical professionals, mothers are often the subject of scrutiny rather than the child (Berman and Wilson, 2009; Litt, 2004; Malacrida, 2001). As Berman and Wilson reveal in their study of intake workers' constructions of mothers who present their children for assessment at a children's hospital, mothers' psychological and emotional profiles are routinely assessed when doing evaluations for ADHD.

The historic, but still prevalent, repertoires of maternal blame, and the subject position of the 'blameworthy mother' are drawn upon and made relevant by mothers of children with ADHD throughout this body of literature. In the majority of these studies, mothers talk of feeling blamed for their children's condition (Austin and Carpenter, 2008; Blum, 2007; Neophytou and Webber, 2005; Litt, 2004; Singh, 2004; Harborne, Wolpert and Clare, 2004; Klasen and Goodman, 2000). In particular, mothers report feeling that their parenting is subject to judgement and scrutiny by others.

The blameworthy mother

It is within this prevailing social context of mother-blame that diagnosis of ADHD is sought. There is some evidence to suggest that within the UK it is mothers who seek medical diagnosis, often contrary to their GP's opinion (Malacrida, 2001; Norris and Lloyd, 2000). Bennett (2007) suggests that while the 'blameworthy' mother is a prevalent subject position, then the medical explanation will always be a desirable repertoire to draw upon. Biological explanations for ADHD are routinely provided by mothers within the literature, with mothers in several of the studies

suggesting their children's 'difference' was evident from birth, or even within the womb (Bull and Whelan, 2006). Certainly, much existing literature reports mothers' relief at a biological explanation for their children's behaviour, as this absolves mothers of any culpability for their child's condition (Neophytou and Webber, 2005; Singh, 2004; Segal, 2001; Klasen and Goodman, 2000). However, there is a body of work that suggests that the blameworthy mother subject position is so pervasive that a medical diagnosis of ADHD, only partially, or only temporarily, absolves mothers of culpability (Harborne *et al.*, 2004). Both Blum (2007) and Singh (2004) identify a mother-blame, brain-blame binarism. However, both also acknowledge that, rather than brain-blame removing mother-blame, the latter becomes 'reconstituted' (Singh, 2004). Blum suggests that once a medical diagnosis is obtained for their children, mothers are positioned (and position themselves) as blameworthy 'proximate causes'. That is, there is an onus on mothers to resolve any subsequent problems or issues their children might have. As Singh argues, post diagnosis, mothers are expected to be vigilant of their children, and prevent any escalation of 'troublesome' behaviour. Any outbreak of such behaviour is because the mother has 'misread' the situation or demanded too much of their sons (Singh, 2004:1202). Diagnosis also brings concerns and feelings of guilt around medication. Mothers are caught in a moral dilemma; do good mothers seek absolution and cure for their children through medication, or is that an irresponsible and possibly abusive course of action to take? As one mother says 'I feel damned if I do give him the pills and damned if I don't' (Taylor, O' Donoghue and Houghton, 2006:120). This guilt is, no doubt, fuelled by media headlines such as '*Unscrupulous parents seek ADHD diagnosis for benefits*' (Goldberg, 2011). An ADHD diagnosis is not only represented as benefiting parents financially; equally, mothers' pursuit of medication is constructed as self-serving in relation to their ability to manage their children and the relief it brings to mother/child

interactions(Singh, 2004). In addition to representing mothers (and fathers) as self-serving, the media can also represent them as neglectful and even abusive in their 'drugging' of their children (Horton-Salway, 2011).

The double bind that mothers experience with regards to medication is indicative of how they can be positioned by the different understandings (or repertoires) of ADHD. The biological repertoire makes available the subject position of the abnormal or 'sick' child, who is adversely affected by a chemical imbalance within the brain. Medication of such a child, to control this imbalance, is, therefore, reasonable, and to be expected. Clearly, this biological repertoire has implications for the positioning of parents. Within this repertoire, parents seeking medication are 'doing right by their child'. However, understandings of ADHD which draw on social and psychological explanations of ADHD (the psychosocial repertoire), make relevant very distinct child and parent subject positions. Within this repertoire, children are constituted as normally naughty, or normally anti-social. Therefore, medicalization is critiqued as being irrelevant and unhelpful. Parents, who pursue the medical route are, consequently, positioned as self-serving or even abusive (Horton-Salway, 2011). Post diagnosis, mothers can be positioned either as irresponsible, abusive mothers who are too quick to medicate their child, or, as 'non-vigilant' mothers who cannot cope with (or control) their child.

The scrutinised mother

Judgement and scrutiny in public spaces features significantly in mothers' accounts. Mothers report feeling judged by other mothers. As Singh states (2004:1201), 'to this extent it does not matter whether mothers are actually experiencing this judgement or 'imagining' it. The point is that even their imagination reflects the internalisation of this disciplinary power'. This (possibly) perceived judgement by others may account for the high number of accounts

which describe feelings of isolation and alienation (Bull and Whelan, 2006; Neophytou and Webber, 2005; Segal, 2001; Klasen and Goodman, 2000) and the withdrawal from social situations. It is little wonder that, as a result of the judgement and scrutiny that mothers report experiencing, they should also report feelings of inadequacy and low self-worth (Bennett, 2007; Singh, 2004).

More positively, the biological/medical repertoire makes available the subject position of 'expert' and 'pro-active' mother, which work to counter the more negative positioning. Malacrida (2001) suggests that to counter their experiences of feeling judged and scrutinised by professionals, mothers work to present themselves in a positive light. The literature reveals that mothers construct themselves as good mothers by positioning themselves as skilled managers of their children's behaviour and as pro-active advocates for their children. Both these positions allow mothers to demonstrate their expertise on their children's condition.

The take-up of these two positions (skilled managers and pro-active mothers) resonates with the two types of carework undertaken by a specific group of mothers of children with an ADHD diagnosis, as identified by Litt (2004); direct carework and advocacy. She asserts that direct carework involves the management of everyday routines, such as behavioural control and managing medication. Advocacy involves mediation, resource acquisition and resource co-ordination. Although this exact terminology is not necessarily used elsewhere in the body of literature, the discursive repertoires relating to parenting skill and advocacy are regularly drawn upon by mothers and researchers and, as such, deserve highlighting.

Mothers as skilled managers

Litt's work highlights the intensity of the experience of parenting a child with ADHD, and how so much of a mother's time is occupied with managing children's disruptive behaviour (Litt, 2004). Although mothers regularly talk about experiencing stress (Bull and Whelan, 2006; Neophytou and Webber, 2005; Harborne, Wolpert and Clare, 2004), a much stronger parenting account that emerges from the literature is one of mothers coping with the situation and, specifically, of mothers learning appropriate strategies and skills to cope with their children (Bull and Whelan, 2006; Litt, 2004; Segal, 2001). Segal (2001) even suggests that mothers undergo a process of 'learned mothering' to become 'professional' parents. Although a cautious approach to accepting such labels and processes as literal must be taken, it is interesting that so much of the literature refers to the development of appropriate coping strategies; as Wilkinson and Kitzinger (2000) suggest, talk of coping is not to be understood literally but as a discursive accomplishment. To be seen to cope is to fulfil a 'socially normative moral requirement' (2000:797). Doing 'good mothering' involves coping with and managing disruptive children. Mothers connect appropriate and successful management of their children with the development of an in-depth knowledge of their children and, within the literature, they demonstrate both subject knowledge of their child's condition (Taylor *et al.*, 2006; Segal, 2001), and also, experiential knowledge of their own child (Hjorne, 2005; Litt, 2004). Mothers' own subjective experience is, at times, drawn upon to critique 'professional' parenting techniques (Bull and Whelan, 2006). Although mothers highlight their willingness to engage with parenting strategies (doing the good mother), they also report the limited success of such strategies.

Another example of how mothers claim expertise and effective management skills is in relation to their children's medication. As discussed earlier, medication poses

its own moral dilemma, and mothers indicate they experience themselves in a double-bind position. Guilt and concern about the side-effects of medication are articulated in several studies (Bull and Whelan, 2006; Neophytou and Webber, 2005). However, this is managed, or countered by mothers, who describe how they provide medication 'breaks' for their children (Neophytou and Webber, 2005; Singh, 2005) or describe how they assume responsibility for the monitoring and 'fine-tuning' of their child's medication (Taylor *et al.*, 2006; Litt, 2004). Not only do mothers demonstrate their developing expertise in relation to their children's medical condition, but they also demonstrate their maternal concern and care for their children's health by providing examples of how they, partially, resist regulated medication of their children.

Mothers' claim to expertise is also employed by mothers when occupying the position of pro-active mother, a position which resonates with Litt's second type of caregiving; advocacy.

The pro-active mother

Existing literature highlights how expertise is drawn upon by mothers to negotiate with professionals and to provide authority to their demands and concerns.

Malacrida (2001) cautions against assuming a 'unilateral direction of power' that emanates from professionals; mothers are prepared to challenge professional perceptions of their children (Todd and Jones, 2003; Norris and Lloyd, 2000).

Mothers are presented as active in the pursuit and conveyance of knowledge about their child's condition (Segal, 2001; Klasen and Goodman, 2000). Mothers draw on their own experience and reading to establish warrant for their knowledge and, indexically, position themselves as experts in relation to ignorant others; several studies report mothers as seeking to educate others about ADHD (Taylor *et al.*, 2006; Harborne *et al.*, 2004,). The ignorance and hostility of others is a

theme that appears in several of the studies, and the language of 'battle' is used (by mothers and by researchers) to position mothers vis-à-vis their metaphorical enemies, that is, other parents, teachers and medical professionals (Blum, 2007; Harborne *et al.*, 2004; Norris and Lloyd, 2000). Blum (2007) suggests that post-diagnosis, mothers are positioned within powerful authoritative discourses (medical, educational, political) and have little 'natural' authority of their own. She suggests that within this context, 'good' parenting becomes a project of 'concerted cultivation' (Blum, 2007:204), by which mothers in 'doing' good mothering take up intensified action by claiming authority to speak and act on behalf of their children. Blum puts forward the idea that mothers become vigilant in their advocacy role, particularly in managing their children across the educational and health care systems and ensuring their access to appropriate resources. This take-up of pro-active, advocacy work by mothers is commonly identified within this body of literature (Austin and Carpenter, 2008; Taylor *et al.*, 2006; Litt, 2004; Norris and Lloyd, 2000) and is, perhaps, indicative, as Austin and Carpenter claim, of new ideas of what constitutes 'good' mothering. Is 'good' mothering of 'disadvantaged' children aligned with notions of activism, action, resistance and advocacy? In Litt's study (2004), mothers assert that it is through their 'special efforts' that their children 'are doing as well as they are' (Litt, 2004:636), suggesting that mothers are positioning themselves as good mothers by drawing on their pro-active mothering and by furnishing their accounts with examples of their competence and expertise. This resonates with Horton-Salway's (2012) suggestion that the 'valourised representation' of the campaigning mother is discursively produced through accounts of the 'victim identity' for the boy with ADHD (2012:9).

Although the active, resistant mother is one possible subject position that is made available through repertoires of good mothering, it is also, as mentioned earlier in the chapter, a risky position to assume. Active and resistant mothers can also be

constructed as troublesome, especially in their encounters with professionals. Mothers work to undermine these constructions by drawing upon their own expertise and knowledge, and/or by assuming the subject position of compliant mother, in their attempts to represent themselves as 'good' mothers.

Expertise and compliance

As discussed, the subject position of 'pro-active' mother makes relevant notions of resistance, activism and advocacy. However, as Malacrida (2001) suggests, power is exercised by mothers not only by confrontation, but through cooperation and the use of 'superior knowledge claims' obtained from articles, specialist sites, journals and books. The accessibility, and subsequent routinisation, of expert knowledge results in the erosion of specialised knowledge and enables lay people to confront experts, not from a position of ignorance but from a position of knowledge. Certainly, the study by Norris and Lloyd (2000) demonstrates that mothers are not afraid of challenging medical opinion that is reluctant to diagnose ADHD and, indeed, it is through the use of medical knowledge that mothers challenge these doctors' opinions.

It would appear that mothers exercise power in the diagnostic process of ADHD by drawing on available, often expert or specialist discourses. However, despite this exercise of power by mothers, the power situated in institutions and practices of expertise still has the potential to constrain and dominate. As Malacrida (2001) points out, mothers, despite feeling anger or resentment at the professionals have to find ways of presenting their knowledge and expertise of their children to the professionals without threatening their expertise. Resonating with Berman and Wilson's study (2009) described earlier, Malacrida points out that mothers have an understanding that confrontation with the experts might result in undesirable consequences for their children and so, acknowledge a need to 'be deferential and

compliant in order to be part of the team and in order to gain referrals to the next rung of the ladder.’ In this sense maternal compliance can be understood as a form of ‘game playing’ (Austin and Carpenter, 2008), in which mothers ‘concertedly’ present themselves as compliant, in order to gain advantage.

The literature on mothers of children with ADHD reveals the competing repertoires of the ‘good mother’. Repertoires of maternal activism and battle compete with repertoires of compliance and vulnerability and make available distinct subject positions for mothers to occupy. However, the overarching repertoires which are drawn upon almost routinely by mothers, whether of children with ADHD or not, are those of ‘doing right by their children’ (Taylor *et al.*, 2006), ‘doing one’s best’ (Harden, 2005) and ‘putting their children first’ (Ribbens, McCarthy *et al.* 2000).

In the final section of this chapter, I turn to the literature around fathers and ADHD.

3.6 Fathers and ADHD

As noted, mothers are foregrounded in the literature relating to ADHD, which is interesting if we consider the gender imbalance in diagnoses (Bailey, 2009).

Fathers are largely absent in the literature on parents and ADHD, perhaps reflecting Singh’s suggestion (2003) that fathers are usually absent throughout the ADHD diagnostic process, a view supported by several studies which focus on child assessment procedures within institutional sites and which only mothers attend (Berman and Wilson, 2009; Hjerne, 2005).

It is interesting that despite the disproportionate prevalence of ADHD amongst boys, there is no clinical explanation as to why this should be so. Similarly, there is no clinical explanation for prevalent understandings that ADHD is genetically carried by fathers and passed on to their children (sons) (Horton-Salway, 2012; Schmitz, Filippone and Edelman, 2003). Although fathers are genetically

implicated in accounts of ADHD, Horton-Salway (2012) points out that this does not invoke moral accountability; in *this* respect, fathers remain free from the blameworthy narrative. However, although 'blame' is not a specific construct highlighted in relation to fathers within the research literature, fathers do talk about feelings of guilt and shame (Gray, 2008; Singh, 2003). It is also interesting that despite the dominance of the discourse of mother-blame within the research literature, fathers are positioned as morally accountable within accounts which align ADHD with deficit fathering, in particular with regard to notions of authority and discipline.

The blameworthy father

Several studies, predominantly from within the more traditional developmental psychology field, implicate the cause of ADHD with particular fathering styles. In particular, there is an association within the literature between ADHD and authoritarian or excessively controlling fathering (Keown, 2011; Rogers, Wiener, Martin and Tannock, 2009; Gerdes, Hoza and Pelham, 2003). Typically, within this work, fathers are reported as being 'overreactive' (Keown, 2011) and their 'negative fathering' and 'aggressive disciplinary practices' (Rogers *et al.*, 2009) are linked with disruptive behaviour in children.

Even studies that are not concerned with finding causal links for ADHD reproduce the association of fathering with authority and discipline. Bull and Whelan's study (2006), for example, notes that mothers typically raise fathers' authority as an issue in their talk of their partners' interactions with their children. Interestingly, however, and echoing the findings described in the previous paragraph, fathers are presented by some mothers as being ineffective and requiring supervision in their dealings with their children, but by other mothers as having more effective 'control' over their children than mothers do.

The alignment of fathering with authority and discipline is one also identified by Horton-Salway (2011 and 2012). Significantly, and conversely, however, she argues that fathers are typically positioned in relation to debates about the association of ADHD with a contemporary **lack** of parental (father) discipline. Specifically, this perceived 'lack' of discipline is contrasted unfavourably with the 'old fashioned discipline' of the past (Horton-Salway, 2011:543). As outlined earlier in this chapter, a concern with declining paternal authority is one that is embedded within the wider social and political context and one that is identified within sociological literature (Barnes and Power, 2012; De Benedictis, 2012; Yarwood 2011; Gillies, 2005).

Whilst acknowledging the distinction between authoritative and authoritarian parenting, it is significant that accounts which seek to attribute cause/effect relationships for ADHD, make available two distinct and potentially opposing repertoires in relation to fathers and children with ADHD. On the one hand, fathers' excessive authority is considered a contributory factor to their children's ADHD; on the other hand, fathers' lack of authoritative presence is also constructed as being an influence. Seemingly, fathers are positioned within contrary ideologies of what constitutes effective fathering, resonating with Billig *et al.*'s concept of an ideological dilemma (1988).

Although there is some indication within the literature that, through ineffective fathering practices, fathers are held morally accountable for their children's ADHD, there is little consideration of how fathers experience, or orient to, the subject position of blameworthy father (unlike the dominant focus within literature of how mothers orient to the blameworthy mother position). One exception is Gray (2008), who suggests that fathers make relevant the disciplining, authoritative father

subject position in their accounts to counter pervasive accounts of irresponsible and deficit fathering.

Much of the more sociological/social psychological literature around fathering and ADHD indicates that fathers are more likely to be resistant to the medicalization of their children's (sons') behaviour, with suggestions that this is due to fathers' identification with their sons.

Fathers' identification with sons

Singh (2003) suggests that fathers are sceptical of ADHD as a diagnosis and show resistance to understanding their children's behaviour within a medical framework. She also suggests that fathers identify with their sons' 'symptomatic behaviours' and are reluctant to interpret such behaviour medically as this risks pathologising their own childhoods. This is supported by the accounts of mothers featured in Segal (2001) and Harborne *et al.*'s study (2004). In the latter study, mothers reported fathers as having a 'different understanding of the difficulties' (2004:336) and as seeking to normalise their children's behaviour. Harborne *et al.* also indicate that it is not only fathers who identify themselves with their sons, mothers too, identified similarities between the behaviour of their sons and their sons' fathers.

The gendered bias of media representations of ADHD might offer a further insight into why fathers identify with their son's ADHD and are more reluctant to pursue the medical route. As Horton-Salway (2012) points out, media representations of ADHD produce two opposing constructs of ADHD masculinity: the hero and the villain. Typically, the hero construct (which within media representations is exemplified by a description of Winston Churchill) is put forward as a 'valourised representation' of aspirational masculinity (Horton-Saway, 2012:11), and is offered as a rhetorical counterpoint to biological and medical understandings of ADHD.

Arguably, fathers' identification with their sons, and their resistance to medicalization, is a result of investment in this discursive construct. This resonates with Singh's observations (2005) that fathers account for their sons' ADHD behaviour as evidence of 'authentic boy-ness'. As she comments, fathers' accounts 'ascribed meaning and value to stereotypic gendered behaviours and rejected the notion that these behaviours were inherently problematic' (Singh, 2005:43).

3.7 Summary

Existing literature seems to indicate that mothers and fathers engage with ADHD in distinct ways; mothers' take up of the biological repertoire is contrasted with fathers' (initial, at least) reluctance to accept the medicalization of their child's behaviour (Singh, 2003) and this might suggest that distinct identity work is being done in their construction of understanding of ADHD.

The chapter has demonstrated that within existing literature, mothers of children with an ADHD diagnosis orient to key subject positions, principally, the 'blameworthy mother' and the 'valorised mother' (Blum, 2007). The 'blameworthy mother' is oriented to in accounts which describe their experience of (their parenting) being subject to judgement and scrutiny by others. The 'valorised mother' is made relevant through mothers' talk of maternal activism, and maternal 'coping'.

The Chapter has noted that fathers are predominantly absent within the literature. However, there is a growing body of literature in which fathers are genetically implicated in accounts of ADHD (Horton-Salway, 2012; Schmitz, Filippone and Edelman, 2003). The chapter also acknowledges that many traditional psychological studies are concerned with associating distinct fathering styles with ADHD, in particular, excessively authoritarian fathering styles.

The limited focus on fathers within the existing literature is addressed in this current research project and fathers will be the focus of Chapter 8. The apparent gendered bias of ADHD diagnoses towards a focus on boys and their mothers necessitates an exploration of fathers' engagement with the condition. This is particularly resonant within a social and political context that seems to be increasingly aligning troublesome childhood behaviour with weak parenting and a lack of authoritative presence.

Chapter 4 Methodology

4.1 Identifying a theoretical framework

As demonstrated through having two distinct literature chapters, there are two 'objects' of interest in this research project. Broadly, the two 'objects' of study are ADHD itself, and the identity of parents of children with an ADHD diagnosis. With regards to the diagnostic category of ADHD, traditional and realist approaches to the study of such phenomena hold that these medical categories come into being through the development of increasing scientific knowledge. From this perspective, diagnostic labels are given to diseases and illnesses that pre-exist in the world (Horton-Salway, 2007; Tait, 2001). Such categories are understood to have an objective reality, which is independent of social and cultural contexts and the way people describe them.

Chapter 2 problematised this version of medical phenomena by outlining the shifting historical, cultural and social understandings of ADHD, which contribute to its contested status as a medical category. The variance in diagnostic rates and competing bio/psycho/social explanations all suggest that the 'reality' of the category is contingent upon the context within which it emerges. Clearly, this has implications for the ontological status of social phenomena such as mental health categories (see Harper, 1995). Instead of representing medical realities, mental health categories (or labels) are understood to be mediated, and constructed, by historical, cultural and social processes.

Chapter 3 reviewed the existing literature on parents of children with ADHD. As noted, most existing research is located within the sociological/social psychology and developmental psychology disciplines. As Gray (2008) outlines, the majority of sociological research relating to parents and ADHD adopts an interpretivist epistemology, with a common focus on the reported subjective experiences of

parents. Developmental psychological research, on the other hand, adopts a more positivist epistemology and is concerned with quantitative methodologies which seek cause and effect relationships between measurable and observable behaviours. Despite their distinct epistemologies, these approaches share an uncritical stance towards language. In the former, language is uncritically accepted as a tool which conveys the 'truth' about personal experience or feelings. Similarly, in the latter, the use of questionnaires or observation to establish parents' preferred parenting styles highlights how language is understood to be a representational device for reflecting universal, objective truths (see Keown, 2011; Rogers, Wiener, Martin and Tannock, 2009). Within these epistemologies language is understood to be 'owned' by the speaker, and deployed in the transmission of unique and individual experience and beliefs. Parents' accounts are understood to be representative of the 'truth' of what actually happened or what was experienced. Similarly, within these studies identity is conceptualised as being located within a bounded individual, who is assumed to be separate from society. Identity is understood to be fixed and stable, and can be accessed via the descriptions and accounts of the individuals in question.

By contrast, if we extend the ontological approach adopted in relation to mental health categories to identity, identity is treated, not as an inner, essentialist structure, but as a phenomenon which is both given and actively produced (Wetherell and Edley, 2009). Parents' accounts are, thus, not mined for 'truths' about their beliefs or experiences, but are examined for how they (their accounts) are shaped by linguistic resources available in the wider social context and how the availability of such historical and cultural resources are implicated in the production of identities. Unlike the realist and essentialist approaches outlined in the previous paragraph, this ontological position necessitates a theoretical

framework which is concerned with knowledge construction and the constitutive role of language (Willig, 2013).

This chapter will argue for a critical discursive psychological approach to the study of parental identities in relation to their experiences of having a child with ADHD. It will begin by describing the turn to discourse in psychology. It will then discuss the competing discursive approaches of conversation analysis and Foucauldian analysis, and show how the theoretical framework adopted for analysis is a synthesis of these traditions. In particular, the usefulness of three analytic tools will be presented: the use of rhetoric, interpretative repertoires and subject positions. The theoretical framework is very much implicated in the choice of methods and analysis, and these will be presented in the final section of this chapter.

4.2 The turn to discourse in psychology

Discursive psychology

Discursive psychology emerged in the mid-to-late 1980s as a critique of cognitivism (Willig, 2013; Wetherell, 2007). Key figures and works in the early development of this approach include Potter and Wetherell (1987), Edwards and Potter (1992, 1993), Antaki (1998), Billig (1996), Billig *et al.* (1988)

Discursive psychology rejects the dualism inherent in cognitivist approaches to the study of psychological life. Within cognitivism, psychological 'topics' such as identity, attitudes and mental states have been theorised as cognitive-perceptual phenomena, contained within an isolated, private individual. Such phenomena are, typically, investigated using experimental, or realist methodology. In line with its social constructionist foundations, discursive psychology is interested in the performative nature of everyday language use. It rejects the notion that cognition can be accessed directly and transparently via talk; instead, it is concerned with *how* people talk, and how, through linguistic practices, psychological life is

constituted. Edwards and Potter (1993) make claims for the understanding of language as social action in their Discursive Action Model (Horton-Salway, 2001; Edwards and Potter, 1993). This model is concerned with the way in which ‘descriptions and versions of events are constructed by speakers and writers to perform social actions’ (1993:25). Particular focus is on action, fact and interest, and accountability in talk. Rather than accepting that language illuminates cognitive or social reality, opinions and attributions are seen to be situated in ‘activity sequences’, such as blaming and defending (Edwards and Potter, 1993:24). An example of this is provided here from the data collected for this research project. Ingrid is talking about how she has finally decided to medicate her son after some initial reluctance: ***now I think I’m the other way, you watch these programmes with people who’ll refuse to medicate and I think that’s completely wrong now because you see that even though it’s medication they do need it because they are... you know... there’s not the right connection up there.*** A traditional approach to this talk, would consider Ingrid’s statement to have provided a transparent route to her internally held ‘opinion’ that it is completely wrong not to medicate. This ‘opinion’ would be considered as fairly stable and constant (although there would be acknowledgement that something tangible had caused her to change her opinion at some point). The opinion that ‘it is wrong to medicate’ might be identified as a thematic category across the data set, and, instances of this opinion might be counted and compared with those parents who express an alternative view. However, if we alter the emphasis of our research question from ‘*What is Ingrid (her talk) saying?*’ to ‘*What is Ingrid (her talk) doing?*’, our conclusions would be very different. Considerations of the second question might lead the researcher to conclude that Ingrid is justifying her decision to medicate her son by constructing a version of people who don’t medicate as somewhat stubborn. This is done through her use of language to

convey persistent and dogged insistence; they will refuse to medicate. 'Refuse' can suggest a problematic form of agency, and so, in working up an account of these people as being stubborn and problematic, Ingrid not only distances herself from them, but also validates her own decision to medicate. One reason that Ingrid might be justifying this decision is that she is being interviewed by a psychologist, who, through the recruitment process, has problematized the parental experience of having a child with ADHD. For a social constructionist approach, variability is not problematic. Indeed, it would be anticipated that Ingrid would offer different accounts in different situations to fit the requirements of the social context.

So, as exemplified, enquiring about what language is doing rather than what it is saying shifts the analytic focus from individual, cognitive events and processes to social interaction. As Hepburn and Wiggins state (2005:595), discursive psychologists are concerned with 'how 'psychology' and 'reality' are produced, dealt with, and made relevant by participants in and through interaction'. It is through language and interaction that individuals negotiate and formulate such psychological concerns as identity, group membership, social categorisation and attributions (Widdicombe and Wooffitt, 1995). Central to a discursive psychological approach is that language is implicated in the construction of moral psychological selves. Talk is understood to perform moral work as its aim is to present a 'credible and creditable moral position' for the speaker (Burr, 2003:135).

Consequently, this approach emphasises the accountability of descriptions and, specifically, how speakers attend to issues of accountability and responsibility for the actions and events they describe, and also for the discursive accounts they provide (Potter, 1996; Hepburn and Wiggins, 2005; Burr, 2003; Horton-Salway, 2001; Widdicombe and Wooffitt, 1995; Edwards and Potter, 1992). This, therefore, seems a particularly relevant and useful approach to draw upon in exploring how parents negotiate their understanding of ADHD, a disorder which is, of itself, often

subject to critical and judgemental attention and with which parents are morally implicated as outlined in Chapter 3. The main focus of this research is to understand the ways in which the identities of parents of children with an ADHD diagnosis are produced given this moral positioning. The interest of discursive psychology in identifying the discursive techniques employed by individuals in the production and negotiation of their social identities is, therefore, a very pertinent and useful approach for answering this question.

I found Potter's description (2010) of accounts having both an action-orientation and an epistemological orientation a useful framework for, firstly, identifying the discursive techniques, and, secondly, analysing their performative function. Action-orientation refers to what descriptions *do*. For example, are they working to attribute blame or responsibility or to work up an action as common-place. Epistemological orientation refers to how speakers construct their accounts as true and factual. Discursive techniques relating to action-orientation which I have found useful in my analysis include extreme case formulations (Potter, 1996; Edwards 2000; Pomerantz, 1986) three-part lists (Potter, 1996; Jefferson, 1990) and script formulation (Potter, 1996; Edwards, 1994). With regards to the epistemological orientation of descriptions, I have drawn on the following techniques in my analysis: interest management and stake inoculation (Potter, 1996; Horton-Salway, 2001; Edwards and Potter, 1993), category entitlements (Potter, 1996; Sacks, 1995; Widdicombe and Wooffit, 1995), empiricist discourse (Gilbert and Mackay, 1984; Woolgar, 1988), footing (Goffman, 2001), and reported speech (Stokoe, 2003, 2009; Stokoe and Edwards, 2007). Many of these techniques are drawn from conversation analysis, and I explain and illustrate them as they appear in the data chapters 5–8.

Discursive psychology is influenced by theories located within disciplines including sociology (Goffman, 1990, 1971), semiology (Barthes, 2006), anthropology (Geertz, 1973) and philosophy (see Potter, 2001 for a discussion of Wittgenstein) and this accounts for the distinct epistemological divisions within the approach. Some discursive psychologists align themselves with conversation analysis and ethnomethodology, suggesting analysis should be restricted to the immediate interaction of research interest (see the debate between Schegloff, 1997, 1998; Wetherell, 1998; Billig, 1999). Other discursive psychologists, however, argue for a synthetic approach combining fine-grain analysis with a consideration of the influence of wider cultural, historical and power relations (Seymour-Smith, 2008; Wetherell, 2007; Seymour-Smith and Wetherell, 2006).

4.3 A synthetic approach

This synthetic approach, sometimes identified as critical discursive psychology (Wetherell, 2007), is the one adopted for this study. The next section provides a brief outline of the fine-grain discursive traditions of conversation analysis and ethnomethodology, followed by a description of the broader post-structural Foucauldian discourse tradition. It will then argue for a synthetic approach to discursive psychology, which draws on both of these traditions.

Ethnomethodology and conversation analysis

Ethnomethodology is the study of people's methods for 'producing and making sense of everyday social life' (Potter and Wetherell, 1987:18). Originating with the work of Garfinkel (1967), it is a sociological approach concerned with how individuals of any given community construct and account for everyday activities. It emphasises how individuals make shared sense of their situations and how, through shared assumptions about the world, further intelligible (inter)action

develops (Heritage, 2001). It is through shared meanings that the production and recognition of an individual's (or actor's) behaviour becomes accountable.

The emphasis in analysis is, therefore, not on the content of accounts, but on what shared knowledge is being assumed and how this impacts on the development and direction of the interaction. For example, in an extract from one of the interviews in this study, one of the participants, Ingrid, says: ***oh yeah, I've been to three parenting groups (laughs)***. A non-ethnomethodological analysis might consider that this is an example of Ingrid's ability to laugh at her situation, evidence of her taking 'things' lightly, or, in her stride. An ethnomethodological analysis, however, is interested in the actual development of this interaction, and what this might indicate about shared knowledge. Her laughter is not met with reciprocal laughter by the other people in the interaction, but is responded to by an anecdote (from the other interviewee), which is critical of parenting groups. In everyday communication, laughter is typically responded to with reciprocal laughter by listeners in order to build affiliation (see Jefferson, 1984); however, here, the shared understanding is that this is not intended as a humorous statement, but one that signals this is an account of 'troubles'.

It is through shared understandings of such social practices as laughter that talk in interaction is made intelligible. It is through commonly shared methods of joking, or arguing or criticising, that individuals come to present particular versions of themselves (Wilkinson, 2004). So, in the example above, through the 'serious' take up of Ingrid's laughter by the audience, a shared understanding that these experiences are actually not funny is accomplished. As Jones (2003) suggests, this approach necessitates that the ethnomethodological researcher step back from the *apparent* 'stuff' of the interaction, and, instead, focus on the social

practices and processes which are attended to in conversation, but which are rendered invisible in everyday life.

This is a very pertinent consideration with regards to the focus of this research study. The parents of children with an ADHD diagnosis are the objects of much scrutiny and advice - giving by experts. In order to be deemed compliant, and, therefore, a 'good' parent, as one father, Michael, indicates: ***you do have to play the game***. Realist assumptions about parents' compliance would interpret it as indicative of acquiescent parenting, and could interpret the expert strategies as being popular and successful. However, an ethnographic account of parents' apparent compliant behaviour might reveal that rather than compliance, parents amongst themselves are, in fact, resisting expert intervention.

Conversation analysis emerged in the 1960s from the work of Sacks (1995), Schegloff, and Jefferson (see Heritage, 2001). Although very much influenced by ethnomethodology, its primary focus is the 'nuts and bolts' of conversational interactions. Analysis is concerned with the strategies and techniques used in managing interaction and building accounts (Burr, 2003). Its focus is on the orderliness of talk (Heritage, 2001, Widdicombe and Wooffitt, 1995, Potter and Wetherell, 1987) and how the sequence of conversational turns and participants' orientation to immediate concerns performs particular actions. Accounts are, thus, understood to be determined by the local and specific occasion in which they are formulated and are not understood to be a representation of pre-existing thoughts, beliefs or experiences. Conversation techniques are understood to be normative in that if they are breached, then actors can be held morally accountable and, so, may need to perform some 'repair' work to get the interaction (or their presentation of self) 'back on track'. An example of such a conversation technique used frequently by the participants in this study is the structure 'at first I thought, but

then I realised...’ (Jefferson, 2004; Sacks, 1995; Wooffit, 1992; Edwards, 1991; Pollner, 1974). This technique is often used to construct the rationality and neutrality of the speaker when accounting for ‘unusual’ or controversial attitudes or actions. It is used by speakers to indicate that their everyday common sense has been disrupted by unusual facts that cannot be denied (despite their wishes). In this way, the device is used to manage possible interpretations of the speaker as having an interest or stake in a particular version of events (Potter, 1996). It is typically drawn upon by the parents in this study when accounting for their seeking a medical diagnosis for their children. By invoking this discursive pattern, parents resist the understanding that they were predisposed to interpret their children’s behaviour as ADHD, and were jumping on the ADHD bandwagon (see Horton-Salway, 2007 for a discussion of the bandwagon effect). Crucially, the absence of such a discursive pattern leaves the parents morally accountable for why they initially sought diagnosis.

Similar to ethnomethodology, the conversation analyst is required to put aside all preconceptions or ontological claims about what is ‘going on’ within interactions, or what people are ‘essentially’ like (Wetherell, 2007; Burr, 2003). Instead, the only legitimate objects of study are those made relevant by the interactants within the moment to moment interaction. Schlegoff argues that conversation analysis is (and should be) informed by naïve epistemology and methodology (Billig, 1999); a topic is considered relevant only if participants orient to it within their talk. This emic approach to data collection clearly has implications for the role of the researcher. According to Schegloff (1997) analysts should not impose their own categories onto participants’ talk. Accordingly, macro-discursive resources relating to notions of gender, class, and ethnicity are not relevant unless made so by the participants within the interaction.

A conversation analytic approach also has implications for the way speakers are understood, in particular, with regards to issues of agency. By emphasising the fluctuating, context-dependent orientations of participants' talk, participants are afforded far more agency than within some discursive approaches which adopt a far more deterministic view of discursive practices. By theorising individuals as having a qualified degree of agency, the analysis undertaken in this research study has attended to the methods used by participants in their take-up and resistance to undesired representations of themselves.

Foucault

A Foucauldian approach to the study of discourse eschews the fine-grained micro analysis of conversation analysis in favour of the macro analysis of social structures, social relations and institutionalised practices. Rather than the sole emphasis being on language, discourse, within this approach, is understood to be 'a system of representation' (Hall, 2001). Foucauldian researchers are interested in the way that rules and practices within given historical periods regulate discourse, that is, regulate what can be meaningfully said, and what can be meaningfully known. The way discourse is shaped by global politic-meaning, history and dominant 'narratives' of knowledge are questions that interest Foucauldian researchers, and answers to research questions are sought within the domain of social relations, culture, government and politics.

As a constructionist theory, the Foucauldian tradition maintains that 'we can only have a knowledge of things if they have a meaning' (Hall, 2001:73). Thus, concepts such as madness, sexuality and punishment cannot exist, or not be maintained, without recourse to the prevalent historicising discourse (Hall, 2001). This clearly has resonance with the shifting understandings of ADHD, and psychopathology in general, outlined in Chapter 2. As argued, shifting

understandings of psychopathology have been shaped by the knowledge produced by dominant institutions such as the church, the law and, most recently, medicine (see Foucault, 2003, 2006; Lemma, 1996). Mental illness, has, for example, been variously 'known' within religious discourse (in terms of evil spirits), within moral discourse (a failure of morality), within a psychological, specifically, psychoanalytic, discourse (poor maternal attachment), and, within biomedical discourse (biochemical imbalance) (see Lemma, 1996 for an extended discussion of this). As I argue in Chapter 2, these historically shifting understandings of mental health do not emerge as a result of scientific progress. Such understandings are not given up in favour of 'better truths'; instead, they 'hang around' and can co-exist with each other. A Foucauldian understanding of discourse's relationship to 'the self' is that it constructs historically, and culturally, specific 'ways of being' and 'ways of seeing' (Willig, 2013). Specific subject positions are constructed through the dominant discourses of the time. According to Foucault, it is important to consider which systems of knowledge (or regimes of truth) are used to talk a 'being' into existence, and within which sites these 'objects' (Rose, 1999) emerge, because it is within these systems of knowledge that power circulates. Discourse and knowledge both sustain, and are sustained by, institutional practices and these institutional practices are legitimately enabled to regulate 'that' of which they talk. For example, as both Willig (2013) and Burr (2003) indicate, within medical discourse, the subject positions of 'patient' and 'medical practitioner' become available, and it is legitimate, and even expected, that medical treatment is the regulatory practice which will be undertaken. Certainly, an awareness of the historicising discourses around mental health has been useful in analysing parents' talk and in, partially, informing what discursive resources parents might be drawing upon. My analysis of the data suggests that ADHD is understood, at various times, as a moral, psychological and/or

biomedical category (by the participants in this study and also by 'others' of whom the parents talk). These different understandings of ADHD make available very different subject positions for the children affected by an ADHD diagnosis, and so too the parents. They also legitimise and de-legitimise certain regulatory practices.

Another Foucauldian concern which has been particularly useful for my analysis is that of surveillance and its internalisation. According to Foucault, people come to monitor their own behaviour through existing regimes of truth and regulatory practices (Singh, 2004; Burr, 2003; Rose, 1999). The 'psy complex' is a term coined by Nikolas Rose (1999) and used to refer to 'all the practices and professions with a 'psy' prefix which play a central role in the surveillance of and regulation of people in contemporary society' (Burr, 2003:72). As Rose suggests, psychology is central to the construction of normalising notions of childhood and is also central to developing normative assumptions about what constitutes good parenting and appropriate parenting strategies. An awareness of the disciplinary effect of such psychological discourses has been useful when considering parents' accounts of normality and abnormality in relation to their children, and also when considering parents' accounts of their own parenting strategies. Significantly, surveillance and scrutiny, as topics, are dominant themes that parents orient to in their talk, with particular reference to how they feel their parenting is judged to be deficient. The performance of parental knowledge can also be considered a manifestation of the internalisation of surveillance and regulatory practices and can, therefore, be interpreted as a performance of parental moral authority. A Foucauldian sensibility destabilises taken-for-granted notions of normative development and normative parenting practices, and this has the potential to be liberating and politically challenging.

A Synthetic Approach

A synthetic approach is one promoted by Wetherell (1998, 2007) and taken up by many researchers in the field (Wetherell and Edley, 1999, 2009; Seymour-Smith, 2008; Jones, 2003). This approach argues for a synthesis that 'pays attention to *both* the situated and shifting nature of discursive constructions as well as the wider social and institutional frameworks (of meaning, of practices, of social relations) within which they are produced' (Willig, 2013:127). Within such an approach, attention is paid to both discourse practices (what people do) and to discursive resources (what people draw on); the former permits an understanding of *how*, for example, identity is formed, and the latter permits an understanding of *to what effect*.

The main critique of a Foucauldian approach to the study of understandings of the self is the limitations it affords agency. The focus on institutional practices and historicising discourse, which is central to a Foucauldian approach, risks obscuring or even erasing the 'subject'. Within such an approach, the construction of selves is understood to be restricted by the discourses of particular sites and institutions, and individuals are understood to have limited capacity for change. Holstein and Gubrium (2000) resist this understanding of the constitution of selves, and suggest that identities are discursively shaped by the intersection of multiple discursive resources such as class, race, gender and ethnicity, and also by our involvement in aspects of everyday life such as family, relationships and jobs. Crucially, and chiming with Wetherell (1998), they argue that Foucauldian approaches overlook the constitution of selves that occurs within the local and particular contexts of social interaction. They posit that discourses deployed in the construction of self are available at the local as well as the wider social context. As they state, 'the moral climate of the self we live by is located at the working crossroads of

institutional discourses and everyday life, in the interplay of discursive practice and discourses-in-practice' (Holstein and Gubrium, 2000:232).

Conversely, the main critique of conversation analysis (CA) is that it is too focused on the talk-in-interaction and participants' concerns. As Stokoe, Hepburn and Antaki (2012) suggest, discursive psychology informed by CA (and within which they position themselves) is critiqued for ignoring 'macro' concerns such as power, politics, culture and ideology. These criticisms are refuted by Stokoe *et al.* (2012) and Hepburn and Wiggins (2005), who argue that conversation analytic informed discursive psychology actually 'opens up these topics' as it reveals how such topics are systematically made relevant in interaction. Indeed, they argue that such analysis can be a powerful tool for social change and point to CA influenced discursive psychology, which has, indeed, concerned itself with accounts relating to wider social concerns such as political disputes, racism and prejudice (Potter and Wetherell, 1987, 1992), nationalism (Billig, 1995) and gender and sexuality (Kitzinger and Frith, 1999).

However, such wider social concerns as these are only considered if made relevant by the participants within the immediate interaction. Wetherell (1998, 2007) is critical of the CA informed preoccupation with the minutiae of conversational turns and its disregard of the wider social context in which talk takes place, unless, of course, such external contexts are made relevant by the participants in the immediate talk (Schegloff, 1997, 1998, 2006). The focus of analysis within discursive psychology informed by CA is to show how 'interactions are put together and knowledge-in-practice is made, describing the regularities and forms of order underpinning this making' (Wetherell, 2007:671). Attempts to go beyond the text and ground such constructions within a wider social framework are considered to be a kind of 'theoretical imperialism' (Schegloff, as cited in

Wetherell, 2001c), a practice which imposes the researcher's theoretical assumptions on the talk being analysed.

While a synthetic approach still values analysis of participants' orientations in interaction, it does not restrict its 'analytic attention to what is going on, for the participants themselves' (Edley, 2001a:190). This highlights a fundamental schism between the discursive psychology informed by conversation analysis and that which advocates a more synthetic approach. As Jones says (2003:61), 'one of the areas of major disagreement between different discursive approaches is about what status 'participants' orientations' should have'. The emic style of analysis advocated by conversation analysts is particularly championed by Schegloff (2006, 1998, 1997), who argues that the only topic of concern for analysis should be participants' orientations. According to Schegloff, analysts should not impose their theoretical concerns or import their own categories into participants' discourse, arguing that such prior theorising inevitably results in finding out what is already known (see Billig, 1999). Schegloff's claims that conversation analysis is based on epistemological naivety are challenged (Billig, 1999; Wetherell, 1998). In particular, and paradoxically, considering its own critique of etic styles of analysis, it is challenged for imposing its own analytic frame of reference on participants' talk. Analytic terms such as accountability and extreme-case formulations, for example, are not terms used by participants themselves. Billig (1999) also argues that conversation analysis ignores its own rhetorical practices, and through processes of 'attending and disattending' to data, the analyst imposes their own view on the selection of data. Consequently, such an analytic approach results in a restricted and unacceptably narrow gaze (Seymour-Smith, 2008; Wetherell, 1998), which privileges fragments of highly transcribed text. Wetherell advocates that investigation of identity necessitates a move away from talk-in-interaction or knowledge-in-practice. This approach is one adopted by Jones' in her study (2003)

of older women talking about sex. She suggests (2003:62) the analyst needs to consider 'absences and silences' in data that are indicative of implicit, taken-for-granted assumptions of (with regard to my own study) gendered behaviour or good parenting. These implicit assumptions do not necessarily appear in the data as participants' concerns in the way understood by conversation analysts, 'however, they are in the data in that the analyst, by drawing on their knowledge of other ways in which it could have been talked about, can see that things have been framed in a particular way' (Jones, 2003:62).

A concept that permits a focus on both local meaning making practices and broader cultural phenomenon is Laclau's analogy of discourse as an 'argumentative texture' (Wetherell, 1998, 2001c). Within each (arbitrary) fragment of text selected for study lie the threads of a broader discursive 'fabric'; these argumentative threads, therefore, work across different domains and enable a less restrictive definition of participants' concerns to include 'the broader argumentative structure of their particular utterances' (Jones, 2003:63).

The branch of discursive psychology which aligns itself with the methodological principles of conversation analysis identifies itself as a theory of discourse rather than a theory of psychology or society, and this is one of Wetherell's main criticisms of the approach. According to Wetherell, the limits imposed by this approach on bringing the psychological and social into studies of identity are misguided (Wetherell, 2007). Although Wetherell shares discursive psychology's understanding that everyday accounts are infused with ontological claims about the world, she disagrees with its prescription that analysis should be free of ontological claims. Contrary to discursive psychologists (for example, Edwards, 1997) who claim that the analyst 'should not add further ontological claims of our own about what is really going on, and what people are really like, but should

simply describe how participants do it and in this way build cumulative knowledge of people's practices' (Wetherell, 2007:671), Wetherell calls for an analytic approach which combines epistemological constructionism (the study of *how* identities are made) with ontological constructionism (the study of *what kind* of identity is made). She argues against separating the personal from the cultural or the social from the psychological. Such an approach inevitably requires an understanding of the social and cultural resources that are drawn upon in the shifting construction of selves in communications with other people. Analysis, therefore, needs to pay attention to both the 'situated nature of accounts as well as the institutional practices and social structures within which they are constructed' (Burr, 2003:22).

Analytic tools which permit an analysis of both local meaning making practices and broader issues of power and culture include the concept of the rhetorical nature of talk, interpretative repertoires and subject positions. I draw on these concepts throughout my analysis and in the next three sections discuss their theoretical underpinnings and methodological use in relation to my own study.

The rhetorical nature of talk

Within discursive psychology, the idea of the disengaged, atomistic self, expressing unique and personal beliefs is challenged (Davies and Harré, 1990). The psychological self is conceptualised as 'noisy, dialogical and distributed' (Wetherell, 2007:664). Language, both in speech and thought, is understood to be infused with social and cultural discourses which are taken up or undermined according to the performative work that is being accomplished. Ideology not only infuses language but becomes part of our psychology; as Wetherell states (2007:664), 'thinking is suffused with dialogue, with the words of others, and those words bear the marks of their social contexts of use and historical struggles over

meaning'. This conceptualisation of the ideological nature of thought is one developed by Billig, Condor, Edwards, Gane, Middleton and Radley (1988). They argue that prevailing ideology is dilemmatic and often contains contrary themes which are then taken up by individuals when constructing their 'common-sense thinking' (Billig, 2001:214). These *ideological dilemmas* appear in speech, revealing that people possess contrary linguistic resources for talking about social phenomena. Pertinent to my study was a consideration of the ideological dilemmas inherent in talk about health and illness, specifically in relation to notions of parental responsibility and expert responsibility for managing children's disorders.

Discursive psychologists such as Billig (2001, 1996) highlight not only the dilemmatic nature of discourse but also its rhetorical and dialogic nature. Following Bakhtin, Billig (2001:214) highlights the dialogic nature of statements, claiming that 'attitude statements tend to be uttered as stances in public controversy' and are made in relation to counter positions, or alternative versions. By this, Billig is suggesting that speakers do not only attend to the immediate audience, but to other imagined, and probably critical, audiences. In considering that discourse is always attending to a critical counter position, it can be understood to be concerned with argument, persuasion, criticism and justification. I found this a very useful concept when analysing the data, as my instinct suggested that parents were defending and justifying their parenting practices even though the immediate context did not necessarily demand that they should.

Two other concepts which challenge the atomistic understanding of individual expression are, first, Bakhtin's concept of *heteroglossia* (see Maybin, 2001), which is used to refer to the dynamic multiplicity of voices contained within language. Language is 'not a neutral linguistic resource, but is already 'overpopulated' with

other people's voices, and the social practices and contexts they invoke' (Maybin, 2001:67). The second concept, and one drawn upon frequently in this study, is the analytic concept of *interpretative repertoires*.

Interpretative repertoires

The concept of interpretative repertoires first appeared in Gilbert and Mulkay's (1984) sociological study of scientific discourse: *Opening Pandora's Box: A Sociological Analysis of Scientists' Discourse*, in which they identify two 'broad' ways of talking about science adopted by scientists working in the field. When legitimising scientific endeavour, scientists employed an empiricist 'way of talking' (or repertoire); when accounting for error in scientific efforts, a contingent repertoire was adopted. That is, these scientific efforts were formulated as having failed because of 'contingent' variables such as personality or unhelpful characteristics, emotions or beliefs. As Silverman (2001a:180) points out, neither of these ways of talking conveys the 'essential form of scientific practice'. The discursive interest lies, not in asking 'what is science?' but 'how is a particular scientific discourse invoked? When is it invoked?' and 'how does it stand in relation to other discourses?'

Gilbert and Mulkay (1984) also observed that speakers moved between these two ways of talking depending on the context in which they appeared. Within formal contexts, scientists tended to draw on an empiricist register whereas within informal interviews scientists would draw on the contingent register. These different repertoires were seen to be systematic and meaningful and to perform different functions: the empiricist repertoire was particularly drawn upon when accounting for a scientist's own scientific belief, and the contingent repertoire was drawn upon when accounting for other scientists' scientific error. As Potter and Wetherell (1987:152) argue, 'the asymmetrical pattern of accounting for 'correct'

and 'false' belief' reconciled 'the basic idea of the empiricist repertoire – facts arise naturally from experimental findings – with the observation that other scientists regularly seem to get them wrong', thus allowing 'each scientist to maintain a coherent version of their social world which featured their own beliefs as the unthreatened truth' (Potter and Wetherell, 1987:153).

Following Gilbert and Mulkay (1984), a repertoire can be understood to be a recognisable and systematic way of talking which deploys specific arguments, linguistic terms and descriptions, and which can be said to perform particular evaluative work. I found this a useful way of systematically approaching parents' descriptions of ADHD. It became evident that two linguistic patterns to describe ADHD were regularly drawn upon by the parents in this study and I detail these in Chapter 5.

Burr (2003:60) defines an interpretative repertoire as a 'culturally shared tool kit' and suggests such repertoires are used to 'justify particular versions of events, to excuse or validate behaviour, to deter criticism and to maintain a credible stance'. These shared understandings are inferentially rich, and so, only a fragment of the repertoire is necessary for meanings to be conveyed and responded to (Seymour-Smith, 2008; Burr, 2003). The culturally shared understandings which underpin interpretative repertoires implicate discourse at a micro and macro level. Thus, interpretative repertoires are a useful analytic tool to bridge the micro and macro discursive divide as they permit the researcher to consider how social discourses available at a broader level are deployed within the 'highly occasioned and locally variable nature of talk' (Jones, 2003). Interpretative repertoires are similar to Foucauldian discourses in that both are discursive resources located within a broader social context than the local interaction. However, interpretative repertoires are smaller scale, less deterministic, locally available and deployed in

particular situations to perform different functions. Above all, they are highly flexible resources which can be reworked according to the context. This explains the presence of sometimes contradictory repertoires across accounts and even within the same accounts, as indicated in Gilbert and Mulkay's study (1984).

The theoretical concept of ideological repertoires has been described and used by discursive psychologists (Horton-Salway, 2011; Seymour-Smith, 2008; Edley and Wetherell, 2001; Edley, 2001a; Silverman, 2001a; Potter and Wetherell, 1987) and applied to different topics such as gender, masculinity, parenting and media representations of ADHD. Ideological repertoires are useful for understanding how linguistic resources are implicated in the performance of identities and in managing local understandings of the self. For example, Silverman's study (2001a) reveals how a mother of a teenager draws on potentially exclusive repertoires of both parental responsibility and young adult autonomy when accounting for her own parenting practices. In so doing, she is 'able to resist being positioned by the doctor as either 'nagging' or 'irresponsible' (2001a:181). The culturally shared meanings around parental responsibility and young adult autonomy are mobilised in this mother's interaction with the doctor in the production of local identity. Crucially, such studies reveal that although different interpretative repertoires have different subject positions associated with them, they are *resources* for speakers rather than discourses that impose specific subjectivities on individuals (or ways of understanding selves). Similarly, within my own study, I identified that through the mobilisation of distinct repertoires of ADHD, distinct parental identities are made relevant, and either resisted or taken up by the parents. A useful analytic concept for thinking about this is that of subject positions, a concept developed by Davies and Harré (1990).

Subject positions

A turn to discourse acknowledges the constitutive power of discourse and discursive practices such as interpretative repertoires. The deployment of certain repertoires, makes available distinct subject positions which, once taken up, results in the individual seeing 'the world from the vantage point of that position and in terms of the particular images, metaphors, story lines and concepts which are made relevant within the particular discursive practice in which they are positioned' (Davies and Harré, 2001:262). The fact that such subject positions pre-exist the individual and circumscribe the experiences and interactional rights that can be claimed suggests that individuals are constrained by available discourses. Whilst acknowledging the constraining effects of culturally available discourses on human experience, the concept of subject positions theorises individuals as much more actively engaged in the local production of identities. Subject positions are theorised as being highly indexical and variable depending on the demands of the situation. Seymour-Smith (2008) talks of individuals having a 'portfolio' of positions which are available for use within different contexts. The shifting and dynamic take-up of subject positions points to their importance as sites within which individuals attend to issues of accountability in their formulation of moral selves. The availability of several 'possible selves' (Davies and Harré, 1990) means that representations of identity can appear contradictory and inconsistent. In my analysis of the subject positions that were available for fathers, I identified that fathers, at various times, made relevant an 'ignorant' (not knowing) father, while at other times made relevant an expert (highly knowledgeable) father.

Such flexibility in the representation of self can thus lead to potentially conflicting representations of self and so, in order to appear rational and morally coherent, individuals are also concerned with resolving or legitimising such contradictions in their talk. Specifically, contradictory representations of the self challenge common-

sense, Western understandings of a unified, coherent and consistent self.

However, it is, perhaps, this acceptance of inconsistency which partially validates subject positions as a theoretical concept. Inconsistencies point to the constitutive and indexical nature of discourse. However, the very fact that these inconsistencies make sense, to speaker and audience alike, points to a shared repository of meaning. Just as with interpretative repertoires and ideological dilemmas, the variability and inconsistency in the take up of subject positions can be seen to reveal that ordinary thought is dilemmatic and infused with a common ideology (see Billig *et al.*, 1988).

The concept of subject positions, therefore, permits (and accounts for) the presence of contradictory accounts in talk. Clearly, however, an analysis of talk cannot only be concerned with variability. The identification of regularity and consistency within data is a necessary requirement of social scientific study. The concept of subject positions is a tool which permits the systematic charting of 'any patterns which might be revealed' (Wetherell, 2007). Certainly, with regards to this study, it was notable that all the fathers formulated themselves as fathers concerned with maintaining a disciplinary presence.

As Burr (2003) suggests, both interpretative repertoires and subject positions are useful for the micro discourse analyst concerned with how individuals negotiate their identities within particular social interactions and by the macro discourse analyst concerned with the constitutive force of subject positions. Individuals are conceptualised as being produced by discourse but also as being manipulators of discourse (Burr, 2003). In this sense, interpretative repertoires and subject positions can be seen to afford the individual more agency than the historicising discourses suggested by Foucault. Individuals are understood to be capable of exercising choice in either claiming or resisting subject positions that are made

locally available. Davies and Harré (1990) also highlight the uniqueness of an individual's take-up of a subject position, emphasising the influence of personal history and experiences.

Despite increasing research that adopts a critical approach to ADHD and parenting, much of the existing literature on parents' (mothers') experiences of ADHD situate parents' experiences within a very broad context of discursive practices (see Singh, 2004, 2002a; Malacrida, 2004, 2001; Todd and Jones, 2003; Norris and Lloyd, 2000). The focus in these studies has mainly been on how mothers are positioned within grand social and cultural discourses, and how power is deployed through these discourses (and resisted by mothers). However, emphasising the powerful nature of dominant discourses, such as medical classifications, potentially risks undermining or, at least, ignoring mothers' (and fathers') own understanding and construction of ADHD within local interactions.

Whilst acknowledging the importance and significance of these studies, there are relatively few studies which have employed a synthetic approach to the talk of parents of children with ADHD (Gray, 2008 is an exception). The synthetic approach adopted in this research study follows the tradition advocated by Wetherell (2007, 1998), which incorporates both fine-grain micro analysis and more macro-cultural perspectives. Specifically, it examines how parents manage identity and accountability in relation to ADHD within the immediate context, while considering this accomplishment with reference to the resources available within the broader social context. Identity is treated, not as an inner, essentialist structure, but as a phenomenon which is both given and actively produced (Wetherell and Edley, 2009). The parents in this study are understood to deploy (either by taking up, or undermining) the available historical and cultural resources in the production of selves. Although the focus of the analysis is on the fine-grain

detail of parents' constructions of self and each other, knowledge of the broader context is used to make sense of the patterning of the interaction. This is done through the use of theoretical concepts such as interpretative repertoires (see Horton-Salway, 2012; Potter and Wetherell, 1987; Gilbert and Mulkay, 1984), and subject positions.

Such an approach is, therefore, an important one as it both draws attention to the potentially limiting discourses which delineate parents' experiences and position them as (im)moral actors vis-à-vis their children, and also acknowledges the possibility of personal and social change through a 'capacity to identify, understand and resist the discourses to which [they] are subject' (Burr, 2003:125). In this way, the concepts of interpretative repertoires and subject positions are not only analytical tools but can be seen as emancipatory tools in a person's attempts to resist or claim particular identity formulations.

4.4 Generating and capturing data

Recruitment and participants

As the focus of this research study is on how parents negotiate their identities through talk of their experiences of having a child with ADHD, this clearly, necessitated recruiting parents of children with ADHD. A convenient way of reaching such a group was via support groups. It was anticipated that recruitment would be dependent on an opportunity sample, and for this reason, a desired number of participants was not specified. I made contact with the gatekeepers of two local support groups, who subsequently forwarded my invitation to take part in the research project to their emailing lists (see Appendix A). My invitation requested volunteer parents willing to be interviewed within a discussion group and individually or as a parental couple. As existing research (Singh, 2003) indicates that fathers are largely absent (certainly in the diagnostic stages) from

their children's diagnosis, I anticipated that more mothers than fathers would volunteer and, consequently, my invitation emphasised that I would particularly welcome the contribution of both parents to this research.

I had seventeen responses, all, bar two, from mothers; however, four of the replies from mothers indicated that their (male) partners would also be interested in taking part. These respondents were then sent an information sheet about the project and a consent form (see Appendix B and C). Of those who replied, three did not take part in the study at all (two did not appear at the discussion groups and one lived too far away to be able to arrange a mutually convenient time). So, the final cohort of respondents consisted of nine mothers, who presented individually, one father, who presented individually and three mother/father couples.

With the exception of gender, which was identified from the existing literature as a relevant concern, no demographic information was requested or, particularly, noted. This is common to discursive approaches which argue that such information does not neutrally represent participants' identities, but contributes to their very construction. As Willig (2013:121) states 'such information out of context suggests particular social categories capture the essence of people placed within them'.

The research process: the practicalities

Two discussion groups were held to accommodate the geographical situation of the two support groups. The first discussion group was held in a local community centre out of which that particular support group operates. This discussion consisted of seven participants, five mothers presenting individually, and one mother/father couple. The second discussion group was held in a local children's centre, which, again, was used by the particular support group, and consisted of five participants, two mother/father couples, and one mother presenting

individually. All the respondents were invited to come to the discussion groups, but not all were available on the selected days. Although all respondents had been sent information sheets and consent forms via email, these were re-issued prior to the commencement of the discussion group and consent to participation was obtained. At the end of the discussion group, participants were asked to give their consent for their contributions to be used for research purposes. They were also asked if they would like to take part in follow- up individual or couple interviews.

From discussion group 1, two of the mothers and the couple took part in the follow-up interviews. All of the participants from discussion group 2 took part in follow-up interviews. Additionally, three mothers and one father were interviewed, providing ten interviews in all. Three of the interviews took place in the participants' homes, four took place at the community centre where the first discussion group was held, one took place at a local college and one took place in a quiet room attached to a café.

All discussions and interviews were digitally recorded and transcribed. As Speer and Hutchby indicate (2003), the use of audio recordings is well founded in the collection and analysis of data across a range of social scientific approaches including social and discursive psychology (see Potter and Wetherell, 1987).

Despite criticism that suggests the use of audio recording can have an adverse effect on the interaction between the researcher and researched, and can, consequently, have a contaminating effect on the talk produced within the interview, I would argue that this is no 'worse' than other, supposedly less intrusive, methods such as note-taking. Indeed, as Willig suggests (2013: 31), note-taking may have a negative effect on the development of rapport between interviewer and interviewee as eye-contact and non-verbal contact is not maintained. Similarly, Speer and Hutchby note (2003: 316) that in contrast to

methodological approaches which advocate the use of field notes, audio recordings minimise the ‘interpretive filtering effect’ that inevitably occurs when the researcher is concerned with writing up their version of the interaction. The argument that audio recording renders research interviews as ‘non-natural’ is challenged by Speer and Hutchby (2003) who demonstrate that the presence of recording equipment becomes a participant’s topic of concern within the research interview, and that, rich, insightful and natural interaction is produced around the very topic of recording.

Whilst acknowledging the increasing use and usefulness of video recording to the development of research and clinical practice (see O’Reilly, Parker and Hutchby, 2011), I opted for audio recording for two key reasons. Firstly, as O’Reilly *et al.* (2011) suggest, the use of video recording raises certain ethical concerns.

Participants are visually identifiable, and this clearly has implications for data protection. This could, potentially, have compromised the informed consent given by some of the participants, in particular, one participant who was very concerned about her identity being revealed. In addition, the settings for the interviews were not neutral research spaces; interviews were held wherever it was most convenient or suitable for the participants. Several interviews were held in participants’ homes amongst all the personal possessions that make up home life such as books, photos and parents’ and children’s personal belongings. Videoing in such surroundings would have had several ethical implications including ensuring that no personal detail of people who had not given consent was revealed. Secondly, as O’Reilly *et al.* (2011) point out, video recording is especially useful for identifying the minutiae of interactional patterns. As this study adopts a synthetic approach to data analysis, such fine-grained, micro analysis which focuses on the interactional consequences of both language and non-verbal communication is not necessary, and audio recording is considered a full and

sufficient approach for the analysis of data more concerned with identifying broader, contextual patterns within talk.

Focus groups as a viable discursive research method

There is a well charted history of using focus groups in qualitative social science research, in particular, in research relating to health matters (Wilkinson, 2004, 1998). There is also a tradition of their use in discursive research studies (Horton-Salway, 2007; Puchta and Potter, 2004; Wilkinson, 2004, 1998; Kitzinger and Frith, 1999). The advantages of using a discussion group include its apparent simplicity; its relative efficiency as a data collection method and its capacity to reach a larger pool of participants in 'one fell swoop'. Wilkinson argues (2004) that the dynamic quality of group interaction also produces more naturalistic data than that produced by interviews as a wider range of discursive practices is performed. In an interview, the researcher is engaged as both participant in a conversation and as the collector of data. This can potentially compromise or affect the 'quality' of the language. Focus groups, however, reduce the researcher's participation in the construction of the discussion, which not only addresses issues of equality, but also permits the participants to direct the flow and content of conversation and, thus, provides a space for a more 'authentic' 'participant language' to emerge. Consequently, Wilkinson argues, focus groups may well be better suited to exploring sensitive issues and may facilitate personal disclosures.

There is much debate within discursive psychology about the validity of claiming 'naturalness' with regards to participants' language use in focus groups and interviews set up for research purposes (see Willig, 2013; Hepburn and Wiggins, 2005; Potter and Hepburn, 2005; Edwards and Stokoe, 2004). The main criticism, which is discussed in more detail in the next section, is that in such situations, participants orient to the research context, and, thus, analytic claims can only be

made with respect to the discursive strategies employed within the research situation, and not about discursive strategies used in everyday life. One way of countering this critique is to conduct focus groups within pre-existing groups, and, in particular, within groups which have come together around the topic of research interest; in this way, participants are familiar with one another, and familiar with talking about 'the topic' with one another. The context of a focus group drawn from an existing support group, as in this study, reduces the 'unnaturalness' of the situation.

Certainly, my aim as a focus group facilitator was to generate as 'natural' a discussion as possible. Consequently, the group discussions were set up to be as unstructured as possible so as to remain within the participants' own frame(s) of reference. The two focus groups began with my giving a very general invitation for parents to talk about their experiences of having a child with ADHD, in particular in relation to what had happened before diagnosis, around diagnosis and after diagnosis. An invitation to talk about experiences, rather than opinions and attitudes towards a topic, imposes less risk on participants to 'get a wrong answer' (Puchta and Potter, 2004); experiences are (relatively) value free. The rationale for holding two focus groups and then following these up with interviews was to use the focus groups as an initial exploratory starting point; a common research design (Puchta and Potter, 2004). The focus groups were used as sources of data but also as a form of pilot study in that they informed the themes around which the individual/couple interviews were based.

Another criticism of focus groups is that interaction will be affected by group dynamics. Indeed, Taylor (2001a) suggests that interaction in groups can be 'about' group relations 'rather than about the apparent topic of discussion' (Taylor, 2001a:28). Puchta and Potter (2004) argue that 'contamination' of views (2004:22)

within a group discussion is the very topic of research interest. It is the variability and contradictory nature of accounts which provides insight into how participants perform rhetorical work and attend to issues of accountability.

Interviews as a viable discursive resource method

The epistemology that underpins a discursive psychological approach entails that theory and methodology are inextricably bound. Unlike traditional approaches to data collection, within a discursive approach the interview is a *topic* of research not a research resource. Working within this perspective, I do not claim that the interviews gave me access to the inner thoughts or direct experiences of the participants, nor do I treat the talk as a representation of the reality of social events and objects. However, neither do I treat the talk as being deceptive or unreliable in any way. Rather, the approach taken to the interview talk is that it is produced as an orientation to the local context and to the questions being asked of the participants. Reality is seen to emerge *through* the collaboration of the interviewer and interviewee rather than existing outside of it. Whilst maintaining a concern with *what* interviewees are saying, the focus of my analysis is on the process as much as the content of talk (see Holstein and Gubrium, 2004, 1997; Silverman, 2001a). *How* is meaning locally constructed? and *to what effect*? As Holstein and Gubrium suggest (1997:127), the 'dynamic interrelatedness of the whats and the hows' is a relevant concern in data analysis.

As outlined in the previous section, there is much debate within discursive traditions about the validity of analysing conversation that takes place within the research interview. In particular, there are concerns about whether such talk can be said to be reflective of conversational practices used in everyday life (Willig, 2013; Hepburn and Wiggins, 2005; Potter and Hepburn, 2005; Edwards and Stokoe, 2004) or whether such interaction can only be analysed in terms of it

being representative of the interview context. Much of the criticism comes from the branch of discursive psychology more influenced by conversation analysis, which advocates a research focus on naturally occurring data. Within this perspective, the presence of the interviewer is perceived as having a contaminating effect on the development of 'natural conversation', and interviews are conceptualised as contrived and subject to powerful expectations about the nature of social science research (Potter, 2004). Hammersley and Atkinson (1983) argue that such a view aligns itself with more positivist traditions, which advocate a natural form of data collection which is 'untouched by human hands' and can, thus, claim to be neutral and unbiased. Perspectives that attend to the communicative competencies and practices of everyday, spontaneous conversation are critical of the constraints which interviews are perceived to impose on participants' talk, suggesting that interviews produce highly situated conversational practices, the significance of which cannot be extrapolated to everyday activities. As Widdicombe and Wooffitt (1995:73) argue in their defence of interviews as a suitable method for a discursive approach to conversation, 'it seems highly unlikely that people have a special set of communicative competencies which are exclusive to interviews [...] more fruitful to treat interviews as a method of eliciting rather than constraining speakers' accounting practices'. Instead, the interview should be approached as a site for interaction in its own right; as a site within which 'natural-interaction-in-interview' occurs (Potter, 2004:205).

My approach to the validity of talk produced within a research interview is informed by the approach of discursive researchers such as Holstein and Gubrium (2004) who challenge the idea that naturally occurring talk is any more authentic or unbiased than the talk which unfolds within the interview situation. All social contexts, including the research interview, impact on the production of accounts; although the research interview confers certain interactional rights and obligations

on participants, so does every interactional context. From this perspective, it is not anticipated, or desired, that the interview provides a neutral context from which the researcher extracts information from the participant without contaminating it. Instead, the interview is conceptualised as a site within which both the interviewer and the interviewee are engaged in actively, and mutually, constructing meaning. Unlike traditional approaches to interviewing, which emphasise the importance of 'good' interviewing techniques in order to 'extract' the best kind of information from participants, the approach adopted for this study acknowledges the shared, and active, skills of the interviewer and interviewee in producing a successful interview (Holstein and Gubrium, 2004; Silverman, 2001a). The research interview is a suitable method for a synthetic discursive approach as this approach assumes the importance of shared common-sense knowledge on the success of local interaction. Interviews are mined for how respondents make use of culturally available resources in their construction of events and in the representation of their identities. Participant accounts are not theorised as being novel formulations but are understood to be accounts, reworked and reconstituted to meet the demands of the local interaction. As Holstein and Gubrium (2004:150/151) suggest, meaning constructed within the interview reflects 'relatively enduring local contingencies and conditions of possibility (Foucault, 1979), such as the research topics presented by interviewers, participants' biographical particulars, local ways of orienting to those topics, institutionalised ways of understanding and talking about things, and other accountable features of 'what everyone knows' about a topic'.

Interviews also lend themselves to research concerned with identity formulation as this is. As Silverman (2001a) suggests, issues of identity become salient within a research context. This is particularly true when the research context specifies a particular identity for the research participants, that is, 'parents of children with an

ADHD diagnosis'. Although the interviews undertaken in this study were unstructured and did not dictate specific topics that should be talked about, they all began with a similar invitation to parents to talk about their experiences of having a child with an ADHD diagnosis. An invitation to describe experiences orients the participants to recount past events. So, the parents in this study are invited to talk about past events through the specified 'lens' of being a parent. These accounts are not only reconstructions of past events but also (re)constructions of a particular self and the interview can be seen as a site in which all participants (including the interviewer) are engaged in the process of self-presentation (see Harden, 2005). It was particularly notable that all the parents in this study attended to issues relating to commonly shared notions of good parenting practice.

Although the participants in this research have multiple identities, such as workers, partners, wives, husbands, daughters, sons and campaigners, the demands of this research context singles out the ('abnormal') parent identity (some of these parents were also parents of children without an ADHD diagnosis, but that was not a demand of the research context). Although this raises the possibility of the research process constructing the very object which it sets out to investigate, it is not problematic for a synthetic analysis of the interview material. By making salient particular research concerns, such as parent identities, then the interview can 'incite the production of meanings' (Holstein and Gubrium, 2004:151) relating to these issues. Interview participants are also participants in their culture and, as with Laclau's notion of society as an argumentative texture (Wetherell, 2001c), the discourses and stock of meanings that run through this argumentative texture (society) are going to continue to run through the conversation produced in the interview situation. As Holstein and Gubrium state (2004:154), the interview is a site of interpretive practice, one in which 'the interviewer participates with the

respondent in shifting positions in the interview so as to explore alternate perspectives and stocks of knowledge’.

However, despite an ethical imperative to construct an account of the research process as one which emphasises equality and mutuality between the researcher and participant, it is (presumably) only the researcher who spends time after the interaction painstakingly working over the interactions to find meanings in what was said. It is only the researcher who has automatic access to the record of the interview. Although a discursive approach to talk emphasises local meaning making, and in this sense makes everyone an interpreter or an analyst of the talk in question, the time spent analysing the interaction *after* it has taken place, inevitably confers another layer of meaning to the talk. This leads to a consideration of reflexivity and the role of the researcher.

4.5 Reflexivity as a discursive concern

The role of the researcher

Clearly, research that fits within a social constructionist paradigm, can only, through its own ontological position, claim to produce one version of the truth. My analysis of the talk of these particular groups of parents is just one ‘reading’ of what is being performed (see Willig, 2013; Potter, 2004; Horton-Salway, 2001; Silverman, 2001a; Wetherell, 2000c). In this sense, a discursive analysis of a text can never be completed. As Willig states (2013), “the truth’ is itself not *recovered from* but rather *constructed through*’ the research and analytic process.

This raises axiological concerns about the role of the researcher. Willig (2013) identifies two interpretative research approaches to data produced within qualitative research; an empathic approach and a suspicious approach. The ‘suspicious’ approach, such as the one undertaken in this study, interrogates the phenomenon under investigation (talk in this study) to uncover the processes and

meanings which generate them. Unlike the 'empathic' approach, phenomena are not taken at face value. This approach, therefore, necessitates a theoretical framework with which to interrogate the topic of study and this, in turn, confers the status of expert on the researcher. It also raises ethical considerations regarding the imposition of meaning upon the data by the researcher; as Willig (2013) asks, 'who owns the interpretation?'

It is probable that the theoretical concepts and terminology employed in the analysis of the talk of this group of parents might be unfamiliar to them, and, consequently, the parents might not conceptualise their talk in the same way that I have. However, a synthetic approach to talk-in-interaction necessitates close observation of local orientations and meaning making; a significant analytic concern is how participants draw on shared knowledge to mutually construct meaning. Therefore, analysis is, partially, validated by participants' orientations, across the data set (Jones, 2003; Potter, 2002; Potter and Wetherell, 1987).

I found Jones' discussion (2003) of her attempts to reconcile participants' rights with her own rights as a researcher instructive. In particular, she addresses the issue of 'who owns the interpretation?' By emphasising the joint construction of accounts produced within the research context, she queries whether such accounts actually *belong* to the participants any more than they *belong* to the researcher. In theorising participants as *speakers* in an interaction rather than *informants* who have privileged access to a pre-existing reality, then their interpretation of what goes on within the research process, although clearly significant through their capacity to provide an alternative version, has no more validity than the researcher's.

Analysis and transcription

As a researcher, there is a responsibility towards analysis of data as well as towards engagement with participants. In considering my responsibility as a researcher, I found articles by Yardley (2000) and Antaki, Billig, Edwards and Potter (2003) particularly useful. Yardley argues (2000) that for qualitative research to be considered meaningful, it is essential for researchers to be transparent and coherent in formulating their versions of reality. Transparency and coherence, Yardley argues, are dependent on the quality of the research, and this is informed by the rigour of analysis. This resonates with the discussion by Antaki *et al.* (2003) of common weaknesses in 'so-called' discursive analysis. In particular, they identify under-analysis to be a common failing, suggesting that unskilled analysts tend to summarise 'what is being said' or get carried away with 'spotting' discursive techniques, rather than showing what the discursive feature is accomplishing. This certainly chimes with my initial attempts at analysis, and earlier versions of data analysis chapters were very much focused on *what* was being said, rather than its performative function. This was largely overcome through increased familiarity with a range of discursive techniques, and through guidance provided within the supervision process.

As the interviews and focus groups were unstructured, there was no expectation of what participants would say. An initial transcription of the contents of all the discussions served as the basis for a preliminary analysis. Following a suggested analytic approach set out by Potter and Wetherell (1987), the identification of broad patterns and themes informed the exploratory focus of the discussions.

This initial exploratory focus was followed up by detailed transcription of sections of the recording relevant to the research questions. A discursive psychological approach does not require full and detailed transcripts of entire recordings,

instead, data is selected, and justified, by the patterns revealed within it and the relevance the researcher attaches to it (Taylor, 2001a; Yardley, 2000). Working within a discursive psychological framework, the selection of material was informed by those parts which were considered analytically relevant to the research question.

Transcription

The transcription approach adopted is one already used and advocated in the field (Holt, 2010; Gray, 2008; Smith, 2005; Holloway, 2005). It is a simplified version of the transcription conventions developed by Jefferson (Atkinson and Heritage, 1984). A full Jeffersonian style transcription is extremely useful for a fine-grained analysis of the interactional features of talk (Potter and Hepburn, 2005). Such detailed transcription as advocated by Jefferson (Atkinson and Heritage, 1984) and Potter and Hepburn (2005) can privilege interactional features over the 'substantive topic' (Smith, 2005:310). However, as this is not the focus of this study, such a detailed transcription is not necessary. As argued by Gray (2008), Smith (2005) and Holloway (2005), a 'one size fits all' transcription approach is not appropriate; a useful transcription is one that fits the analytic approach of the study. In this case, the aim is to identify the use of linguistic patterns drawn from the broader context and oriented to within the immediate interaction of a particular group of parents. The transcription approach adopted facilitates the reader in identifying such features considered relevant to this aim (see Smith, 2005:310).

All interviews were digitally recorded and transcribed verbatim by the researcher. Features of talk represented in the transcription included pauses (untimed), overlapping turns, quotation marks to indicate participants' use of reported speech, and the occasional use of punctuation to aid the reading of particularly long extracts. Largely, however, as with the Jeffersonian approach, the talk was left

unpunctuated. Following similar approaches in the field (for example, Gray, 2008), and in keeping with ethical considerations, the anonymity of participants was protected during the transcription process; participants were given pseudonyms, and geographical reference points were also only indicated by their initial letter.

Clearly, decisions around transcription again lead to a consideration of reflexivity, as, obviously, selective transcription is not a neutral process, but one that reflects the researcher's interest and bias, including the focus of their research question.

As Taylor indicates 'a transcript constructs a certain version of the talk or interaction which is to be analysed' (2001a:28). For this reason, it is essential that the researcher adopts a reflexive position in the analysis of the data. There is, potentially, an inherent paradox to claiming the necessity for a reflexive approach.

A reflective stance necessitates considering 'the way a text such as this is a version, selectively working up coherence and incoherence, telling historical stories, presenting and, indeed, constituting an objective, out there reality' (Potter, 2004). This level of reflexivity might risk undermining the version of reality that the analyst has constructed as it would inevitably involve interrogating all the assumptions upon which the research is based, and render it, potentially, meaningless. Arguably, acknowledging the need to be reflexive serves its own rhetorical purposes. As Billig (1996) suggests, aligning oneself with a potentially critical audience can work to deflect criticisms and, in fact, work to protect the identity and integrity of the speaker (in this case, the writer of the text). In this case, an audience might critique such an analysis for demonstrating bias or a lack of validity; in reflexively acknowledging that my version is just one version of the truth, I am inoculating myself against such a criticism.

The somewhat circuitous argument around reflexivity highlights the concerns about validity that a discursive approach raises. Challenges to the adequacy of

explanations offered by a discursive approach can be met by ensuring that research demonstrates the levels of transparency and coherence advocated by Yardley (2000). In terms of transparency, I acknowledge the cautionary reminder by Antaki *et al.* (2003) that such small scale research, as the one undertaken here, does not permit the generalisations of findings to a wider population, in this case to all parents of children with an ADHD diagnosis. With regard to coherence, I have aimed to locate my work within, and build on insights of earlier discursive work relating to ADHD (see Jones, 2003; Potter, 2002; Potter and Wetherell, 1987). By ensuring transparency and coherence, the audience is enabled to decide if the research is meaningful or useful. Readers' evaluation of research as meaningful and useful, arguably, serves as a form of validity (Potter, 2002; Potter and Wetherell, 1987).

4.6 Ethical considerations

My ethical approach is informed by the guidelines provided by the British Psychological Society (BPS, 2009) and by the British Association for Counselling and Psychotherapy (BACP, 2010).

Informed consent

Informed consent was obtained by letter from participants prior to conducting both the focus groups and the interviews. The letters included information on the interview arrangements, the researcher, and the study and how data would be used and stored. There were also details about anonymity and confidentiality and contact details for me and my supervisors, should there be any concerns. All participants were advised that they could withdraw from the study at any point they wished. Consent forms were enclosed with these letters and were signed and returned to me prior to the commencement of the data collection.

Prior to the focus group and the interviews, the contents of the letters and consent forms were reviewed with the participants, to ensure they were still prepared to continue with the process and that they fully understood the implications of being involved in the study. No assumption was made that initial consent equates with on-going consent, and, consequently, consent was requested for each stage of the process. Participants were de-briefed as to the nature of the study at the end and offered the opportunity to read the research report.

Anonymity and confidentiality

The information and consent forms, signed before the beginning of the data collection, guaranteed confidentiality and anonymity to all participants. In the write-up, pseudonyms were used to protect participants' identities.

With regard to the focus group, although it is possible for the researcher to guarantee confidentiality, there is no such 'professional' obligation for participants to guarantee confidentiality to one another. Therefore, at the beginning of the focus group, I negotiated a contract with the group about the nature of the discussion and mutual respect, including the importance of maintaining confidentiality.

De-briefing

I made myself available immediately after the focus group and interviews for initial debriefing (to individual participants) and reminded participants of my telephone number should they wish to be debriefed at a later date. With regard to written debriefing, I asked the participants how they would prefer feedback – suggesting either an anonymised transcript of each stage of the research (depending on which stage the participants were involved in) or a written summary of the main findings of the research (or both). In addition, I offered a report back to the support group of my findings plus a reference list.

Only one of the participants (pseudonym Caroline) requested a transcript of her interview. On reading the transcript she was anxious that she had revealed too much information which made her identifiable. Consequently, she spent some time wondering whether to withdraw from the study. On reassurance that she would be given a pseudonym and that all place names would remain anonymous, she consented for me to use her data. No other participant requested a transcript at that stage although all said they would be interested in reading a final summarised report. In formulating the participants as speakers rather than informants, the requirement for participant feedback to verify the interpretation of the researcher is not so demanded. As Jones (2003:99) states 'whilst much recent work [...] has emphasised participants' rights, it is also important not to lose sight of the analyst's rights to have thoughts with which respondents might not necessarily agree'. The main ethical tension I encountered was around managing potentially sensitive topics. In particular, I was made aware of how, in accordance with discursive approaches to language, marking something as a sensitive topic actually constitutes it as such.

Dealing with sensitive topics

All ethical guidelines point out the importance of sensitive interviewing and as Corbin and Morse (2003) indicate, when research is conducted sensitively and ethically, it can become a beneficial process to both participants and researchers. Following ethical guidelines, all the interviews were set up with the acknowledgement that talking about experiences of having a child with ADHD might be a difficult and upsetting undertaking. All participants were advised of this prior to the commencement of the discussion groups and the interviews and were reminded that they only need disclose information they felt comfortable sharing, and that they could withdraw at any time if the situation became too distressing. Similarly, aware of the potentially sensitive nature of the research topic, my

questions were framed as sensitively as possible. However, the over-deliberation and excessive caution of my questioning does raise issues of what was being set up in the research situation. As Silverman suggests (2001b) such excessive caution works to construct 'delicate' objects, which in turn can position parents as fragile and their experiences as traumatic, when it is possible they may, more typically, construct different versions of their experiences. As I discuss in Chapter 7, the narrative arc of the majority of the interviews has been to begin with trauma. It is only towards the end of the interviews, or even once the recording has finished, that parents describe the more positive experiences of parenting a child with ADHD. It is quite possible that the style of questioning shuts down, or at least, does not invite opportunities for participants to discuss more positive experiences.

Dealing with distress

As Jones (2003) indicates in her discussion of ethics, the boundaries between sensitive research and what other 'experts do' in fields such as counselling and therapy can become blurred. This was a particular tension for me as I practise as a counsellor, and it is quite probable that my 'interviewing style' is more redolent of that used within the talking therapies. Not wishing to blur the boundaries any more than was necessary, I attended the discussion groups and interviews with a list of potential support agencies to provide the participants should I have felt that they were in need of any (or further) therapeutic support. However, I did not pass any of these details as no participant expressed a wish for them.

The tension between my role as a researcher and my practitioner role as a counsellor was particularly difficult when participants became distressed. Within the therapeutic relationship, distress is (generally) mutually understood to be an integral part of the therapeutic process. Distress is not, however, a mutually understood part of the research process. Several of the participants became

distressed when describing incidents involving their children, and tears featured quite regularly in the interviews, as in the following example with Julie.

Julie: *with T I felt really isolated cos I just felt we were completely... every other child was normal and I had the one child the oddbod child and I I did feel very isolated with T you know I just [...] again I wasn't particularly keen on encouraging friendships and things cos I didn't want them to think 'that one's a bit weird' (in a conspiratorial whisper) so yeah that was very isolating*

Alison: *mm*

Julie: *so I sort of got through it with a few friends (voice breaks a little)*

Alison: *mm mmm (pause) it must have really impacted on your ... (J starts crying very quietly) are you ok? Sorry take some time out*

Julie: *sorry (reaches for the tissues)*

Alison: *I'm sorry*

Julie: *no no don't don't be it's just you sort of forgot about it really but then...*

Alison: *it's very...*

Julie: *then you remember just how awful it really was*

Alison: *mm dreadful and so uhm and so raw still really*

One ethical decision to be made is whether to turn off the recorder when participants convey distress such as this. This attendance to the potentially harmful effect of the research situation is informed by extensive feminist research, which is concerned with issues of power and inequality within the research situation (Opie, 1992; Oakley, 2003; England, 1994). However, interpreting all instances of distress as damaging and violating potentially constructs participants as fragile and in need of protection, which may or may not be the case.

Paradoxically, this assumption does not work to reduce the power imbalance

inherent in a research situation but can actually exacerbate it. Julie, in the above example, was aware that she could withdraw from the interview at any time, and at that moment I suggested that she take some time out. However, she continued to recount her story, and so, was exercising her 'right' as a participant to continue.

Certainly, within a conversation analytic approach, crying is understood as a phenomena which has interactional consequences (Hepburn and Potter, 2012), and, in this sense, is not understood as an uncontrolled, outward manifestation of some inner anguish, for which the researcher has responsibility for managing. Crying is theorised as having different forms and functions depending on what is being discursively accomplished at the time. Hepburn and Potter's study (2012) indicates that crying serves several purposes. It can work as a distractor, as a signal to move away from the conversation in hand. Previous research has shown that emotional formulations, such as crying, can also be used to support particular accounts provided by the speakers (Edwards, 1999, 1997) Within this approach, the crying recipient's responses are also implicated with the production of tears. The recipient's attentiveness (as in the example here) is displayed through sympathetic responses which signal that the upset is appropriate and, as Hepburn and Potter (2012:209) suggest, 'cut across issues such as how well the interlocutors know one another, and relate instead to the intensity of the emotional experience'.

Whilst I have some reservations about the lack of account for why individuals might have more emotional investment in certain descriptions than others, the discursive approach to displays of distress does, potentially, afford more of an equal status to the researched/researcher relationship in that the person being interviewed is, theoretically, at least, accorded as much interactional power as the researcher (although it may not feel like it).

The tension between my needs as a researcher and the well-being of the participants is partially resolved by considering that research interviews afford the opportunity for reciprocity. As Corbin and Morse suggest (2003), there are myriad reasons why participants might volunteer for research interviews and it is highly likely that they 'get' something from the experience, such as validation of their versions of events. After all, it is rare that individuals are given an hour or an hour and a half to recount a story from beginning to end with little interruption from the other. In Julie's case she goes on to say that she cried because she had not thought about how difficult it had been for her before her son had had his diagnosis for a long time. In addition, Julie, like most of the participants interviewed, indicated that she hoped her story would help others.

Respect, power and the research situation

The concept of reciprocity was helpful to me in working through issues of power and entitlement, especially with regards to what I was encouraging participants to reveal for, essentially, my own ends. The conversational intimacy which is required for the participant to feel comfortable telling their story risks establishing the researcher as 'a friend' rather than, as Corbin and Morse (2003) say, 'an impersonal professional'.

The development of rapport and conversational intimacy is one that, in everyday conversation, typically involves the giving and receiving of reciprocal disclosures. The dilemma of disclosure has arisen for me on several occasions, but especially when conducting interviews in participants' homes, which I did on three occasions (with Caroline, Jane and Alan and Gill and Mick). As Yee and Andrews posit (2006), the researcher may feel more inclined to reveal more about themselves or their project in someone else's home because they are being good guests. Although disclosure and the development of conversational intimacy need not be

problematic, it might encourage the participant to reveal more information than they had anticipated and which they might later regret. For example, some of the participants that I interviewed admitted going through periods of hating their children. Ethically, I have been troubled by this, wondering how such admissions of strong emotion were experienced by the participants once the research context ended. However, I have come to realise that my own anxiety ignores the very discursive framework that I have set up and used to analyse participants' talk. My anxiety is informed by an overly essentialist notion that participants, in talking about their 'hate' have revealed some innermost 'truth'. Holding this position is untenable within the research approach I employ to analyse participants' talk. Within a discursive framework the expressions of 'hate' articulated by some parents is accomplishing a discursive 'act', whether deployed as an extreme case formulation or as formulating strong emotion as corroboration of a version of events.

Disclosure is not encouraged within the BPS' ethical guidelines; however, there is an argument that sharing information reduces the status difference between the researcher and researched, and there is debate on whether disclosure can lead to a more open and trusting relationship between the researcher and participant or whether it skews the course of the interaction. As Yee and Andrews suggest (2006), too much disclosure 'could block off whole areas of the interview since the interviewee could assume that we already knew about the areas under question'. As an example of this I can compare the data collected from my two focus groups. In the first focus group, following a direct question, I disclosed that I did not have a child with ADHD. The main focus of the ensuing discussion was anecdotal exemplars of how difficult their children's behaviour was. They were scripting an ADHD child for me, as, perhaps, I did not really understand how that would be. In the second focus group, they did not ask me whether I had a child with ADHD, but

I feel that initially, at least, there was an assumption that I did, and possibly as a result of that, there was much less talk about how an ADHD child 'is' and much more sharing of useful strategies for coping and a focus on parenting skills. Again, analytically, this need not be problematic as the focus is on how speakers orient to the highly situated demands of the local contexts. However, the researcher needs to be aware of how such disclosures may be constraining the range of participants' responses.

4.7 Summary

This chapter has outlined my methodological and theoretical approach. I have argued for a synthetic blend of discursive approaches to the talk of parents of children with ADHD. In particular, I have summarised the usefulness of the analytic tools of rhetoric work, interpretative repertoires and subject positions.

I have described how I collected data through focus groups and interviews, and I have provided a reflexive account of my role in the formulation of this thesis as a version of the 'truth'. This led to a consideration of some of the ethical issues which I encountered as a discursive researcher.

Significantly, the discursive approach adopted for this study theorises the participants as joint - producers of interaction, rather than informants who have access to an underlying reality which the researcher is intent on extracting. This, therefore, releases the researcher from discovering and revealing pre-existing truths but instead requires the researcher to examine how knowledge (reality) is produced.

In line with the approach put forward by previous discursive work (Shaw, 2002; Radley and Billig, 1996), this current study focuses on parents' *accounts* of their

experiences, rather than their *beliefs*, and considers *how* these accounts are shaped by linguistic resources available in the wider social context.

In this way, I understand that I cannot make any claims about the speakers' intentions when analysing their language in use and I understand my interpretation of what is happening in the interactions to be just one possible version of the truth.

In the following chapters I present the data from the focus groups and interviews.

In Chapter 5 I look at how parents talk about the category ADHD, specifically focusing on the interpretative repertoires that they draw upon to formulate their understandings. In Chapters 6 and 7 I examine how parents' talk orients to the culturally prevalent binary representations of the blameworthy or valorised mother. Finally, in Chapter 8, I analyse how fathers take-up or resist the subject positions made relevant through the distinct interpretative repertoires available to talk about ADHD.

Chapter 5 Parents' Constructions of ADHD: how do parents account for ADHD?

As discussed in the previous chapters, ADHD is not only a contested category (Rafalovich, 2008; Conrad, 2007; Singh, 2002a; Malacrida, 2001) but one that is, frequently, in public debate, aligned to parents and parenting (Horton-Salway, 2011; Bennett, 2007; Malacrida, 2001; Singh 2004; Singh, 2003; Singh, 2002a). In aligning ADHD with debates about effective parenting, it becomes a moral category; different representations of the category construct different subject positions (Horton-Salway, 2011; Edley, 2001a; Edley and Wetherell, 2001) for the parents of children with an ADHD diagnosis.

This chapter focuses on how a particular group of such parents rhetorically orient to the distinct debates around ADHD. It examines which explanations of ADHD are taken up by them and how these accounts of ADHD are constructed as true. The epistemic nature of parents' descriptions of ADHD is considered in terms of the action orientation of their talk (the social function talk performs) and how parents manage interest and accountability (Horton-Salway, 2001; Edwards and Potter, 1993, 1992). Accepting as a premise the rhetorical and persuasive work of talk (Billig, 1996), the chapter looks at how parents reify certain accounts whilst undermining alternative explanations of ADHD.

5.1 Constructing ADHD as a biological reality

The brain explanation

Extract 1, Paula

Paula: *it's a brain...it's a problem with the brain it's something to do with the uhm frontal cortex or something of the brain and the frontal lobes or something not working properly and the messages and er the way I usually say is it's a bit like*

uhm when messages come in they're like a train and you only get the first and the last bit of that train entering and the middle bit's completely gone uhm and they take a long time to process things [...]so it is it affects the brain and it's a neural developmental problem and and er medication helps put those missing bits back together so they can get all of the message instead of part of it
(laughs)

This extract is typical of how the parents in this study account for ADHD. In particular, the way that parents locate the source of ADHD in the brain. In this extract, Paula draws upon the technical language of neuroscience and refers to locations in the brain; she refers to the **frontal cortex**, the **frontal lobes** and suggests they are **not working properly** due to a '**neuro developmental problem**'. In addition to the technical language, she, crucially, works up the pathology of her son's condition in her descriptions of his brain having a problem and not functioning properly.

Despite drawing on technical language, Paula's biological or scientific account of ADHD is somewhat hesitant and vague ... **it's a problem with the brain it's something to do with the uhm frontal cortex or something of the brain and the frontal lobes or something not working properly and the messages and er...** This fuzziness or vagueness in her account works rhetorically to prevent the undermining of her biological explanation. Paradoxically, in working up vagueness, then Paula cannot be held to account for any confusion or error in her description of what ADHD is (Potter, 1996; Macmillan and Edwards, 1998). Vagueness deflects challenge and, thus, the biological explanation of ADHD provided by Paula remains robust. Indeed, vagueness does not necessarily preclude expert knowledge, as Paula goes on to demonstrate. Paula provides both a biological and metaphorical explanation of ADHD. Her metaphorical explanation of ADHD

being like a train entering a tunnel is prefaced by *the way I usually say is...* This suggests that the metaphorical explanation is given to those people who have no experience, and, consequently, no understanding of ADHD. In switching between the biological and the simpler, metaphorical explanation, Paula displays an expertise about the subject which is warranted by her position as the mother of a child with ADHD (Potter, 1996; Sacks 1995). This category entitlement differentiates her 'expert' knowledge of ADHD from the 'non-expert' knowledge of others who, she implies, would not know about, nor, perhaps, understand the brain explanations. This epistemological warrant to knowledge (see Potter, 1996; Sacks, 1995; Widdicombe and Wooffitt, 1995) inoculates Paula's biological explanation of ADHD from being undermined by alternative explanations of ADHD, such as those outlined in Chapter 2.

Once Paula's entitlement to epistemological warrant has been established, Paula returns to the biological account and formulates the scientific explanation of ADHD by deploying a three-part list *...it affects the brain and it's a neural developmental problem and and er medication helps put those missing bits back together*. As Jefferson (1990) suggests, three-part lists are used to exemplify a more general class of things and in so doing, construct them as 'commonplace or normal' (Potter, 1996:197). Paula's use of a three-part list works to establish her explanation of ADHD as the general, 'typical' one and this again, does rhetorical work in both constructing her account as robust and legitimate and also, therefore, in inoculating it against challenge.

The brain explanation for ADHD is one commonly given by the parents in this data set. It is often drawn upon in conjunction with genetic accounts of ADHD. In the following extract Paula gives her explanation for what she believes the causes of ADHD to be.

The genetic explanation

Extract 2, Paula

Paula: *yes I do believe it's genetic uhm when I look I mean I believe that it must be in my side of the family because my sister's got a boy who's got the same and I've got a boy where they've got different Dads so it can't just all come from the dads some of it's got to come from us uhm but when I look back at my mum my mum was always diagnosed as mentally ill [...] and she's done all quite some radical things uhm but now I know what I know about Asperger's and Autism and stuff I'm 99% sure that she has Asperger's [...] yeah I I di I identified me when I think back uhm I do think there's definitely the Autism is in our family and I even think part the ADHD is there as well although when I was a child I never sat still although I read a lot I would be I'd have music on or I'd be fiddling or [I'd be doing something...]*

Alison: *[there'd be lots of other things going on]*

Paula: *lots of other things going on uhm I could sit but I wasn't one I couldn't sit at school and at school I was quite daydreamy I always remember missing half the lessons cos I was watching what was going on out the window and even now if I'm reading my train of thought goes off after about a paragraph I start I'm reading the words but they're actually going in I'm thinking about other things you know I'll be thinking...[...] yeah so I'm quite sure that there is ADHD in me and I'm quite impulsive at times with things uhm and my sister is very impulsive so I do think that there is ADHD in our family*

Like the majority of the participants in this study, Paula has a son who has a dual diagnosis of an autistic spectrum disorder (ASD) and ADHD. In the above extract, Paula works to construct the facticity of a genetic explanation for her son's

diagnoses of both Asperger's and ADHD. At the beginning of this extract, Paula's account seems to be dialogically and rhetorically positioned (Billig, 2001) against a perceived, or common sense, understanding that the genetic link follows the father line **...it can't just all come from the dads**. This common sense understanding that the genetic link follows the father line might be because of the disproportionate gender bias towards boys in the diagnosis of ADHD (Singh, 2008b; Horton-Salway, 2012). However, Paula grounds her genetic explanation within a description of her own family history. Paula evidences her claim that **it must be in my side of the family** rather than (or at least, as well as) her ex-partner's side of the family through the use of a three-part list (Jefferson, 1990) **...because my sister's got a boy who's got the same and I've got a boy [...]** **when I look at my mum my mum was always diagnosed as mentally ill**. These three examples of similarly 'atypical' behaviour justify Paula's claim that it must be on her side of the family. Paula, again displays her expertise, this time with regard to Asperger's and autism, by drawing on her warrant to knowledge **...but now I know about Asperger's and autism and stuff I'm 99% sure that she has Asperger's** and, similarly, her expertise permits her to authoritatively self-identify as having 'traits' of ADHD and autism **...I identified me when I think back**.

In the following section Paula is documenting both evidence for her claim that ADHD (and Asperger's) has a genetic base and also the category of ADHD. She again uses a three-part list of her own childhood behaviours, which are implicitly used as being instances of a more general category of ADHD behaviour, one to which Paula implicitly claims membership **...I never sat still [...]** **I'd have music on or I'd be fiddling**. The use of the three-part list here works, rhetorically, to provide significant meaning to what could be interpreted as instances of quite typical, ordinary childhood behaviour. She continues by furnishing her account with more examples of childhood behaviours **I couldn't sit at school and at**

school I was quite daydreamy I always remember missing half the lessons cos I was watching what was going on out the window. Although Paula does not explicitly say that these behaviours warrant an ADHD diagnosis, they resonate very closely with common understandings of ADHD, in particular, symptoms of ADHD as outlined by the DSM IV T-R (American Psychiatric Association, 2000), and specifically, symptoms which are often identified within a school setting. Through the use of words such as **would** and **never** and **always** (as in the examples above), Paula scripts those childhood behaviours as being typical and routine for her and as predicates of ADHD. This resonates with the documentary method (identified by Garfinkel, 1984) in which examples or predicates of a phenomenon (such as ADHD) are provided to 'point to' the existence of the phenomena, but are also deployed to further constitute the phenomenon.

Paula's scripted and representative instances of how she used to be work to pathologise, rather than to normalise, the more general class of behaviour which they exemplify (Edwards, 1994). As Edwards suggests, scripted versions of events are 'pragmatically formulated constructions' (Edwards, 1994:214) which are rhetorically designed to deal with accountability for the actions described. Through the very recounting of her own routine and typical behaviours, Paula is suggesting that they are anomalous to the 'normative base' of childhood behaviours.

Normatively shared assumptions (Edwards, 1991) or behaviours would need no such account. In formulating these scripted behaviours, which are so widely associated with the medical classification of ADHD, as 'abnormal', Paula further strengthens her construction of ADHD as a pathological category.

The last two extracts have suggested that as well as deploying brain and genetic explanations, parents also work to construct abnormality in their accounts of ADHD. As mentioned in Chapter 2, abnormality, or at least, abnormal pathology is

very much a feature of the biological explanation of ADHD. Indeed, a biological understanding of ADHD identifies the unruly behaviour of children as being the result of the child's pathological 'abnormality', rather than it being the result of poor parenting or an inadequate environment. Clearly, a label of 'abnormality' does moral work as it potentially absolves parents of any blame for their children's behaviour. It is hardly surprising, therefore, that parents in this study do rhetorical work to establish the pathological abnormality of their children. Extract 3 is an example of this.

Scripting the 'abnormal' child

Extract 3, Donna

Donna: *I knew L was ADHD before he was diagnosed at the age of 7 but obviously they don't diagnose them until they're the age of 7. I used to take him to all the little pre-schools I was the only parent because obviously you have got to sit and interact with them at that age I was the only parent running about after him (laughs) I used to come back like that (shows flagging) he'd still be on the go (laughter) so I did all the right things you know we went swimming we went to the park the farms and all the time he was... we did tumble tots that was another thing and I thought that would be great ... the worst day I've ever had I took him ... cos they're meant to line up and they sing songs and they do this and they do that (?) and he's running about off there and he's pulling it down and he's kicking it and he's pushing in I couldn't it was too much so I did what I could eventually I did get him diagnosed uhm that was really hard I had the same problems with my doctor (turning to J and I) 'this is normal this is what children do' and he's going round his surgery picking up things 'what's this what's that?' 'that's what children do' well my other son never did. Listen my other son's 13 and he's not got any problems apart from teenage attitude*

As Potter suggests (2010), normality and abnormality are indexical; descriptions of abnormality are often constructed in discourse through being contrasted with descriptions of normality. Donna indexes her son's abnormal behaviour in relation to scenes of relative peace and normality at pre-school and also in relation to her other son.

In Extract 3 Donna works to construct her son's unruly behaviour as a manifestation of his abnormality. She describes a 'normal' scene in which mothers and children are typically to be found. Her use of the term ***little pre-schools*** constructs these places as safe, what should be, unproblematic sites, but which, for her, because of her son's behaviour, turn out not to be. As Paula does above, Donna formulates an ADHD script in describing her son's behaviour (Edwards, 1994). Her use of ***used to*** and ***would*** constructs her son's behaviour as dispositional, and representative of how he typically is ***I used to come back like that (shows flagging) he'd still be on the go***. These are not isolated events, this is how he is. She later moves on to using the present continuous tense which gives a vivid urgency to her description ***and he's running about off there and he's pulling it down and he's kicking it and he's pushing in***. The descriptive detail, or focalisation (Potter, 1996), contained in Donna's account of her son's abnormal behaviour persuades the listener they, themselves, are witness to the events, and so works to construct her version of events as plausible and authentic (see Parker and O'Reilly, 2012). Such vivid accounts of abnormal unruly behaviour are difficult to challenge. Donna's repetition of ***I was the only parent*** also indexes her son's behaviour in relation to other children. No other parent was having to do what Donna was doing because their children were behaving in a 'normal', typical way.

In response to her doctor's assertion that her son's behaviour is 'normal', Donna introduces her other son to her narrative. Donna's 'normal' son provides corroboration (Potter, 1996) of her claim that she is aware of the difference between normal and abnormal behaviour (unlike the doctor). He also provides an alternative construct of childhood, a 'normal one'. This son **never did** what her son with ADHD did. Any problems or 'naughty' behaviour displayed by her other son is within the framework of 'normal' naughtiness **listen my other son's 13 and he's not got any problems apart from teenage attitude**. Drawing on her own experiential knowledge and the corroboration of her 'normal' son, Donna is able to confidently construct her son's abnormality.

Establishing ADHD as an objective truth

This chapter's focus is on how parents' descriptions of ADHD are constructed and how the factuality of ADHD, as a biological disorder, is discursively accomplished. In this section, parents work to establish the objectivity of their children's diagnoses through techniques such as stake inoculation (Potter, 1996), establishing out-there-ness (Potter, 1996; Woolgar, 1988; Gilbert and Mulkay, 1984) and the truth will out device (Horton-Salway, 2011; Potter and Wetherell, 1987; Gilbert and Mulkay, 1984).

Extract 4, Kim

Kim: *and I'd rung up the nursery and said this is what is happening at this school er uh this doesn't sound like my child was he like this at nursery and they said 'no he wasn't' but I think it was all the changes and everything so got an appointment within six months so I was really lucky and he got diagnosed then with autism and then six months later she then they uhm the paediatrician gave us another form which we ... I didn't know what it was for and I tick...was filling*

it in and ticking it and when that came in she was 'no he's definite classic uhm ADHD' uhm then and there said 'do you want him to go onto medication' I just said 'no' (with a raised high voice) cos I hadn't even heard of it thought of it anything (laughter in voice) I was just like 'what medic...no? And then she...that was it signed off

Extract 5, Julie

Julie: *and then when he went to primary school the teacher was very worried about his eye contact and they asked us to get him refer ... taken to the GP and get him seen and we thought they know nothing you know oldest child youngest child (unclear) you know the youngest in the class so they were just a bit daft but I did take him along to see the community paed both my husband and I are nurses I work for the children's hospital so every question they asked I knew exactly what to give them so they said no there's nothing wrong with him we went back to school another year of him not coping very well and then uhm he back to the doctor this time they think perhaps he's got a processing disorder of something or other and I wouldn't believe that doctor so I got him referred to London we got him seen in about 20 seconds of me entering the room the doctor says 'he's got ADHD and probably autism' but it took two years of me saying 'no there's nothing...' I just couldn't cope with it I didn't want there to be (?)anything wrong with him so it's quite easy to sort of disguise it then you know I was the one who came out with the excuse that you know like he's the youngest and that so from that point of view I was in denial everyone was telling me there was something wrong with him and I wouldn't believe them [...]*

But with the youngest one, he's got ADHD and he just was ADHD from the moment he was born (unclear) you know he landed in the world and [...] yeah,

and so with him yeah from the age of three I was thinking yeah let's get him referred

The management of stake, or interest, is a key feature of fact construction (Potter, 1996; Edwards and Potter, 1993). The 'objective' reality of descriptions can be undermined if the person providing the description is understood to have a bias or interest in that particular version of events being upheld. As discussed earlier, it is arguably the biological or medical explanation of ADHD that positions parents in a more 'forgiving' light, and, for that reason, it is perhaps unsurprising that parents, in working to establish the biological facticity of ADHD, resist perceived stake attributions by demonstrating initial disinterest or reluctance in accepting an ADHD diagnosis.

Both Kim and Julie do some work in their descriptions to resist being understood as mothers who, initially, anyway, actively sought medical intervention. Kim's description of the events leading up to a diagnosis work to suggest that she and her son, somehow got 'caught up' in the whole diagnostic process. Her account implies her lack of agency in the process ...***and he got diagnosed then with autism and the six months later she then they uhm the paediatrician gave us another form which we... I didn't know what it was for and I tick...was filling it in and ticking it...and***. Crucially, she says that she did not know what the form was for, she was not seeking a diagnosis, it was one that emerged from the process. Her description of the speed of events suggests that the diagnosis had a 'life of its own'. Kim discursively manages to convey her own relative disinterest in obtaining a diagnostic label of ADHD but she also manages to construct the 'out-there-ness' of the diagnosis. The process of obtaining an ADHD diagnosis for her son is constructed as independent of her, almost as an inevitable series of events waiting to happen.

Julie finishes Extract 5 with an emphatic statement of intent to get her son referred to the necessary expert ***yeah and so with him yeah from the age of three I was thinking yeah let's get him referred***. However, this declaration comes after a detailed construction of herself as someone whose stake in obtaining medical intervention was originally counter to this position. Julie presents herself as originally cynical of and opposed to medical intervention ***they asked us to get him refer...taken to the GP [...] and we thought they knew nothing and I wouldn't believe that doctor [...] it took me two years of saying 'no there's nothing...'*** In fact, as she indicates, her reluctance to accept a medical diagnosis lasted two years. Through this technique of stake inoculation (Potter, 1996), Julie avoids any potential to be seen as having a prior interest in getting a diagnosis and strengthens her later claim that a referral is what is required because she is not someone who would, ordinarily, seek this diagnosis.

The objectivity and out-there-ness of the ADHD diagnosis is further worked up by both Kim and Julie by rhetorically contrasting their own disinterest or reluctance in seeking a medical label with the starkly different responses of the professional experts. As Woolgar (1988) suggests, externalising devices are often used in fact construction to establish objectivity. Such devices include divesting reports of agency and drawing on technical authority to support descriptions or claims. An example of an externalising device is the use of active voicing (Potter, 1996; Wooffitt, 1992,) to show an independent corroboration of the description being worked up. In the two extracts above, the 'technical' or expert authority of the medical professionals is actively voiced. In Kim's account the paediatrician ...***was 'no he's definite...classic uhm ADHD'*** while in Julie's description of events ...***in about 20 seconds of me entering the room the doctor says 'he's got ADHD and probably autism'***... The 'truth' of these expert proclamations is strengthened by their contrast to Kim and Julie's initial position. The use of extreme adjectives

and exaggeration: **definite, classic, in about 20 seconds** act similarly to extreme case formulations (see Pomerantz, 1986) and also contribute to constructing the medical diagnosis as the obvious and objective truth. The professionals were not coerced into providing such a diagnosis; they were simply and independently, reporting medical fact.

The construction of ADHD as an out-there, objective reality waiting to be discovered resonates with Gilbert and Mulkay's (1984) work on empiricist discourse and, in particular, the truth will out device, or TWOD, (Potter and Wetherell, 1987; Gilbert and Mulkay, 1984). The impartiality of the author's description is key to constructing objectivity. As we have seen, Julie and Kim manage this through the discursive device of stake management. Kim constructs an absence of interest or stake in obtaining a diagnosis. Julie, however, goes further than constructing an absence of interest, she constructs her initial response as a wrong one. Julie describes her original resistance to a diagnosis as her own **denial**. The 'truth' was always 'there' but it was her inability to see it that was the problem **so from that point of view I was in denial everyone was telling me there was something wrong with him and I wouldn't believe them**. As a result of her denial, her son went back to school ... **we went back to school another year of him not coping very well**... As Julie suggests, the 'truth' of the diagnosis is supported by the fact that her son, without a diagnosis, continued not to cope at school, the symptoms did not disappear, and this is what eventually led her to accept a diagnosis for her son. As Gilbert and Mulkay (1984) suggest TWODs are often used in parallel with accounts of personal error to strengthen the legitimacy of the speaker's current position, which in Julie's case is one of acceptance of an ADHD diagnosis. As she says of her second son ... **from the age of three I was thinking yeah let's get him referred**...

The Truth Will Out Device is also used in the following example of parents' talk of medication.

The dilemma of medication: The truth will out

In this extract, Gill, Jane and Rachel are discussing the issue of medication.

Extract 6, Focus group 2

Gill: *I don't have a problem with it at all*

Jane: *if you look at him*

Gill: *if he needs it for his learning and concentration I'll do it*

Rachel: *I did for a while [...] we didn't go for diagnosis because I didn't see the purpose of it because I wasn't going to medicate because we could manage his behaviour*

Jane: *sure yeah*

Rachel: *but it was when school started saying 'I'm concerned about his education cos he's really bright and not performing' and then we did the diagnosis and talked to the doctor in H (town name) and she was brilliant she was so good and she said 'well you won't know til you try' so it's one of those things there's all these potential side effects there's all these potential benefits and the other thing she said to us was none of the side effects are permanent so you could try it and if they got tics or this or that you would know you'd stop it there was nothing there that was going to be irrevocable is that the right word?*

Gill: *yeah*

Rachel: *so we thought there's nothing to lose and once we as I say we started on ten or twenty, thirty and the difference it made it's just his report at the end 'positive attitude to learning he's contributing it wasn't that there was no problems but the difference in him*

As in the previous two extracts, stake management is a participants' concern in Extract 6. As Julie does in Extract 5 with regards to diagnosis, Rachel constructs her own initial resistance to medication. In response to Gill's claim that she has never had a problem with medication, Rachel says ***I did for a while [...] we didn't go for diagnosis because I didn't see the purpose of it because I wasn't going to medicate because we could manage his behaviour.*** Again, this position is, rhetorically, revealed to be the 'wrong' one ... ***school started saying 'I'm concerned about his education 'cos he's really bright and not performing'*** and one which Rachel reluctantly has to give up. The effects of her own mistaken decision not to medicate are juxtaposed with the positive effects of medication on her son's performance at school ... ***the difference it made it's just his report at the end 'positive attitude to learning' 'he's contributing'***. The success of medication in improving school performance is typically given by parents as justification for medication, resonating with the proverb *the proof of the pudding lies in the eating*. By implication, accounts of the positive effects of medication work to confirm the veracity of the biological explanation of ADHD; another example of the truth will out. Indeed, the objectivity of ADHD as a medical fact is further rhetorically established by constructing a lack of agency in the decision to medicate. As elsewhere in the data set, the impact of the medication is constructed as so life changing and positive that the burden of decision making is almost removed from parents. Although Rachel is the participant who expresses most initial ambivalence to medication, her decision to medicate is finally constructed as one which requires no real choice ***there's nothing to lose.*** If there is no real choice, there is no real dilemma, there is just the objectivity of ADHD as a medical/biological disorder which requires medical intervention.

This understanding of ADHD clearly contrasts with other viewpoints which suggest that ADHD is either a fabricated condition, or one that is caused by a child's

‘deficient’ environment. The following section examines how parents manage scepticism to biological explanations for ADHD.

5.2 Undermining the sceptics

In accepting a rhetorical dimension to fact construction, it is necessary to consider what alternative claims and versions of the ‘fact’ are being undermined (Potter, 1996; Billig, 1996). As Billig argues, rhetorical motive ‘is the motive to justify a position and to ward off criticisms’ (Billig, 1996:191). This is especially pertinent with regard to contested disease categories such as ADHD. In constructing the objectivity of a biological/medical account of ADHD, the parents in this study orient to alternative accounts of both ADHD and the cause of ADHD and work to undermine these explanations. One way in which this is done is through the undermining of knowledge entitlements (Sacks, 1995). Individuals who are sceptical of ADHD, or who offer alternative interpretations of what it is, or how it could be better managed, are constructed by the parents as old-fashioned and out of touch or alternatively, as just ignorant.

Age as a barrier to understanding ADHD

Extract 7, Ingrid and John

Ingrid: *he was just up there and he said there’s nothing called ADHD it doesn’t exist he was a very old doctor he said clearly...*

John: *he’s the (unclear) doctor it doesn’t exist it doesn’t exist and again it goes back to you know it’s obviously your parenting skills they’re not up to scratch*

Extract 8, Focus group 1

Linda: *but you know we went recently (laughs) and he’s really obviously you know anyone on the street would know he had autism and I said ‘oh you know’ and he said ‘why won’t you let me look in his ear with the thing?’*

Ingrid: *laughs*

Linda: *he's got autism spectrum disorder and his GP a senior GP went 'what's that?'*

[...]

Linda: *and you just go 'you're having me on' I mean this was only a couple of years ago so it wasn't cos you know things have massively improved though in the last few years*

Paula: *yeah yeah*

Linda: *but this was I think he's quite close to retirement*

In Extract 7, the doctor is described as not believing in the existence of ADHD. Potentially, this stance is problematic for John and Ingrid as, if ADHD does not exist as a (medical) category, then their son's behaviour has to be interpreted differently. As John says, the implication is that it's ***obviously your parenting skills they're not up to scratch.***

Similarly in Extract 8, Linda describes her son's GP as not knowing about autism. Linda's son has a dual diagnosis of ADHD and autism, and in this particular extract, Linda is talking about ASD. However, the two often become conflated in anecdotes.

Of analytic interest is that in both descriptions, the doctors are constructed as deficient, and that 'age' is suggested as an explanation for this lack of knowledge. In Extract 8, the description of the doctor as ***just up there*** and ***very old*** works to undermine his opinions, in particular, his view that ADHD does not exist. The descriptors construct the doctor as respectively, aloof and unapproachable and, crucially, out of touch.

The expertise of the GP described in Extract 9, is undermined, first, through the claim that ***anyone on the street*** would recognise that Linda's son is autistic. The

use of **anyone** in this example works as an extreme case formulation (Edwards, 2000; Pomerantz, 1986). As Edwards (2000) suggests, extreme case formulations (or ECFs) are often used in the rhetoric of factual description to 'counter challenges to the legitimacy of complaints' (2000:348). In this case, Linda's complaint about the lack of knowledge of the GP is warranted through her assertion that any 'non-specialist' would realise her son was autistic. The doctor's entitlement to knowledge as **a GP a senior GP** is further undermined by Linda's mocking response **you're having me on?** Here, Linda constructs the doctor's ignorance as a joke, and, therefore, his response is not to be taken seriously (Jefferson, 2004; Sacks, 1995,).

As with the previous extract, the doctor's expertise is constructed as deficient and this too is implicitly linked to his age **I think he's quite close to retirement**. Both these doctors are constructed as old, their views as old-fashioned and, consequently, their knowledge claims as inadequate. By implication, ADHD (and autism) is constructed as a modern medical phenomenon which requires a modern understanding and an up-to-date body of knowledge. A modern and young approach is not just required of medical experts as the following extract shows:

Extract 9, Mick, Gill, and Alan (Focus Group 2)

Mick: *uhm ehr how old was the teacher? cos I mean we've had two very young teachers for J and they've both been kind of switched on and I'm not sure if that's how they're being taught now*

Gill: *they're part of the ADD-vance group and they've been trained to (unclear) ADHD and I don't know whether these younger teachers now ...*

Alan: *yeah*

Extract 9 comes just after the focus group have been discussing how they feel schools have, mainly, been unable to cope with their children's behaviour. In particular, Alan and Jane have been talking about one teacher who they feel ***didn't know how to deal with it*** (not produced above). Mick's question at the beginning of Extract 9 immediately makes relevant the topic of age to the teacher's in/ability to deal with their son's behaviour. He accounts for the relevance of this question by associating two positive experiences of teachers with their youth. This idea is taken up by Gill, whose sentence ***I don't know whether these younger teachers now...*** is interrupted by Andy's supportive ***yeah***. However, presumably, Gill was about to corroborate Mick's construction of young teachers as being ***switched on*** and by implication, having more 'modern' and up-to-date knowledge of ADHD, than older teachers.

Undermining 'old fashioned' views on discipline

Extract 10, Gill, Mick, Jane and Alan (Focus group 2)

Gill: *well you see that sort of attitude really frustrates me and I just don't generally get frustrated with J and his behaviour that I have no problems with what really gets me is no offence to your family M but (laughs) when for example we're visiting your nanna or your mum who would... you know that slightly older generation and they don't know about ADHD and to be honest they wouldn't care there's no point us even telling them this is we've told them and they're like 'ah that's nice but he's a boy he should just get on with it'*

Mick: *he just needs a good clip round the ear*

Gill: *and when you go to ...*

Mick: *'a good slap will put him into position' (?)*

Jane: *that's what your dad says isn't it?*

Alan: *yeah*

Jane: *'it never did you any harm' but you said 'well actually you never asked me have you?' and they've obviously tried it with him and they've admitted that it didn't work*

Extract 11, Donna and Linda

Donna: *when my dad comes round he has to sit like that my dad (sitting on hands) like that because in his day (shows slapping) a clipped ear that's how it was dealt with*

Group: *yeah yeah*

Donna: *[...] but my dad's like 'give him to me for a month I'll sort him out ' and I say 'but that is not the answer dad he's been like this since he was born' and I'm not saying that we don't smack L I don't really I've lashed out at him a couple of times because he's just (unclear) he's just gone too far my husband when we're on holiday I mean my husband always goes 'don't shout at him don't shout' right when we're on holiday three days into the holiday waaaaah (laughter) and I'm going 'don't shout don't shout'*

Linda: *it doesn't help (laughter)*

As discussed in Chapters 2 and 3, a common explanation of children's unruly behaviour is that it is the result of a decline in standards of discipline. As Horton-Salway (2011) illustrates, in media representations of ADHD, a lack of discipline is very much associated with contemporary parenting.

Interestingly, parents in this study orient to, and reproduce, the association of physical discipline with an older generation. However, rather than constructing this association between physical discipline and a previous generation as a loss, or as a benchmark against which to judge current parenting practices, parents construct

a disciplined approach to parenting as inappropriate, ineffective and, with its association with the older generation, as distinctly old-fashioned.

In Extracts 10 and 11 participants construct attitudes such as *he just needs a good clip around the ear* as typically, held by older people, *that slightly older generation* because *in his day [...] that's how it was dealt with...* In Extract 10, this attitude is described as a source of frustration and one that, ultimately, does not work *they've admitted that it didn't work*. Similarly in Extract 11, this approach to dealing with Donna's son is constructed as not being the answer. The implication in both these extracts is that the approach to discipline, which is held by the older generation, is uninformed and belongs to a less well informed day and age. As Gill states emphatically in Extract 10 *that slightly older generation [...] they don't know about ADHD*. Donna constructs her father's approach to discipline as pointless and provides the explanation that her son's *been like that since he was born* as justification. No amount of discipline will, or can, change him, he was born that way. It is not his environment which has caused him to be like this.

Donna's undermining of an overly disciplined approach is strengthened by her admission that, on a couple of occasions she has *lashed out*. However, the use of the word 'lash out' suggests an uncontrolled, impulsive reaction to a situation, rather than a reasoned and rational one (see Potter, 1996; Potter and Wetherell, 1987). Physical discipline is, therefore, constructed as emotional and irrational and only used when the child has gone too far and, consequently, pushed the parent into reacting in a dispreferred way.

Parents draw on their own experiences to undermine these 'old-fashioned' approaches to discipline and it is through their descriptions of the failure of such attempts including lashing out and shouting (Extract 11) that they are able to

conclude that such an approach ***doesn't help***. In these examples, entitlements to knowledge or particular opinion are undermined by constructing the holders of such knowledge or opinion as old-fashioned and out-of-touch. The next section examines how claims to knowledge are legitimised through experience (Potter, 1996; Horton-Salway, 2004; Sacks, 1995).

Working up knowledge entitlements

The following extracts demonstrate how the parents in this data set legitimise their own knowledge through their experience of having a child with an ADHD diagnosis. In contrast, the opinion and belief of other people (principally, other parents) is undermined through a lack of experiential knowledge.

Extract 12, Ingrid and John

John: *These people don't listen they're just not interested it was just like 'no basically you're a bad parent' uh uhm 'you've got a naughty child', 'uhm there's no discipline in the household' 'are you a broken family?' 'Are you this?' It's all the clichés that come out*

In Extract 12, John orients to several prevalent accounts of ADHD children and their families. Bad parenting, naughty children, lack of discipline and a breakdown in family structure are all suggested as possible ways in which the behaviour of John's son is understood by 'others'. These different ways of explaining ADHD foreground the impact of psychological and/or social problems on children's behaviour; that is, they posit a psychosocial understanding of ADHD rather than a medical/biological one. John's use of the word 'cliché' also does rhetorical work. A cliché is a commonplace description of a phenomenon that is both well-known and accepted but also over applied, which distracts from its rhetorical force. John's use of the word 'clichés' positions people who hold such views as ignorant and

unknowledgeable about the subject of ADHD. In positioning them as ignorant, then their views are de-valued.

As well as constructing holders of such views as ignorant, in terms of a lack of knowledge, they are also constructed as uncaring and disinterested ***they're just not interested***. So not only are these people uninformed, but they are also indifferent in their dismissal of this family's distress/situation. John works to undermine these people's common knowledge, and also character, and in so doing succeeds in dismissing their version of ADHD as unwarranted.

The objectification of a complaint

The ignorance of other people is also worked up by Jane and Alan in the following example.

Extract 13, Jane and Alan

Jane: *I think people make a lot of comparisons with children on the autistic spectrum as well by saying 'oh yes my nephew's got this that and that and he does that' and I'm thinking 'that's a completely different disorder' although there are some overlaps you're looking at a completely uhm*

Alan: *yeah although they understand Autism they don't understand Asperger's*

Jane: *wh...yeah ADHD and Asperger's they seem to say 'yeah oh it's Asperger's' and it's like 'well we're primarily ADHD' and they're like 'oh well I thought it was sort of the same thing' it's like 'well actually no not at all really' (laughs)*

Alan: *I think we're trying to work out how to say it in a way that uhm ...*

Jane: *[and most people would say 'oh ...]*

Alan: *[...that's educational for them without]*

Jane: *'well my child's like that anyway' and I'm thinking 'well no this is 24 hours a day' and I think that's what most parents find that they may be informed about*

some areas of it but to the extent of how that stops a child and the family leading a normal life that's where it ends I think

Alan: *that's probably a very good point cos they go 'oh yeah my J ...*

Jane: *'oh mine runs up the curtains and does all this'*

Alan: *'yeah and fixates on lego' and I'm like 'yeah but from the moment he gets up to the moment he goes down to sleep to the moment he gets up to the moment he gets to sleep seven days a week'*

Alison: *that's very different isn't it?*

Alan: *for the past four months that type of intensity? no it's in the first you know or in the intensity of every other question of 'can I have it?' 'Can I have it?' 'Can I have it?' or 'I want it' 'I want it' 'I want it' yeah it's not that level of 'oh yes my Johnny wants something now and he's ...'*

At the beginning of this extract, Jane and Alan display their knowledge of the distinction between the different disorders ADHD, Asperger's and autism. Their knowledge and understanding is compared with that of generalised **people** who think these disorders **are sort of the same thing**. In contrast, Jane and Alan's responses are informed and assured: **that's a completely different disorder** and we're **primarily ADHD**. In evidencing their own knowledge, in contrast to others' fuzzy understanding, other people are constructed as ignorant of ADHD (and other disorders).

The unenlightened understanding of others is further demonstrated through the descriptions of their understandings of what constitutes normal/abnormal childhood behaviour. As discussed earlier, there is much at stake with respect to the construction of abnormality/normality. A sceptical view of ADHD interprets unruly behaviour in children within a framework of normality; the child is 'normal',

but has become psychologically disordered (badly behaved?) through an inadequate environment. Within this psychosocial explanation, behaviour is understood as, at best, naughty, at worst, socially and psychologically deviant. This is very different from the biological/repertoire, which interprets unruly behaviour within a framework of biological abnormality. This extract illustrates how issues of normality/abnormality are addressed as participants' concerns. It demonstrates how the construction of Alan and Jane's son's biological abnormality is rhetorically indexed in relation to other children's constructed normality.

Alan and Jane's claim to biological abnormality for their son is rhetorically positioned in relation to other parents' claims of naughtiness for their own children. In order for their claims for biological abnormality to be accepted, other children's naughtiness needs to be minimised in order for it to be understood as 'normal' rather than pathological. Undermining other people's claims about their own children is potentially risky and could be interpreted as mean-spirited or biased. As Edwards (2005) suggests, in building a complaint as a factual description of its object, 'the less available it is to be heard as stemming from the speaker's disposition to see, feel, or interpret things negatively' (2005:6). Alan and Jane work hard to build the objectivity of their complaints about the other parents and, in so doing, manage a, possibly, negative interpretation of their own subjective investment in undermining other parents' claims. They accomplish this through techniques such as active voicing (Edwards, 2005; Wooffitt, 1992) and extreme case formulations. According to Alan and Jane, their child's behaviour is often interpreted as 'normally naughty' by other people and no different from their own children's behaviour (or other children they know) '**well my child's like that**' and '**oh yes, my nephew's got this that and that and he does that**'... Alan and Jane use active voicing (of other parents) to discredit attempts by other parents to normalise their (Alan and Jane's) son. The mimicking of certain comments and

questions serves to mock the understanding of other parents and also minimises the very behaviour that they are complaining of ***oh mine runs up the curtains and does all this*** and ***yeah fixates on lego*** and ***oh yes my Johnny wants that now***. The use of ***my Johnny*** also works to trivialise the claims of the parents; ‘my Johnny’ constructs parents who use the phrase as somewhat over-precious or over-concerned about their children. The objectification of Alan and Jane’s complaints about other parents works to construct these parents’ descriptions of their children as trivial and non-problematic; the implication being that really they have nothing to complain about.

This, however, is not the case for Alan and Jane’s son. His abnormality is constructed in contrast to the normality of other children. In contrast to the minimisation of other children’s behaviour, they work to construct the behaviour of their own son as extreme. Extreme case formulations (see earlier) are used to counter suggestions that their son’s behaviour is normal and to strengthen Alan and Jane’s claim that his behaviour is abnormal. Unlike the behaviour of other children, his behaviour is constant and persistent ***24 hours a day*** and ***but from the moment he gets up to the moment he goes down to sleep [...] seven days a week***. As Edwards (2000) points out, ECFs are used in the rhetoric of factual description because they are difficult to challenge. Even if understood to be non-literal, they serve as a descriptive generalisation of extremity. Additionally, they indicate a speaker’s investment in a particular position, which makes them difficult to undermine. Extremity, or extreme behaviour, is the very substance of ADHD diagnosis, and, so, it is unsurprising that parental accounts tend to construct their children’s behaviour as extreme. Unlike the behaviour of other children, as described by their parents, the behaviour of Alan and Jane’s son is problematic and abnormal.

To summarise, in this section, attempts to understand their son as ‘normally naughty’ are resisted by Alan and Jane. They achieve this by constructing their own son’s abnormality and by undermining other parents’ descriptions of their children’s behaviour. In indexically constructing their own son’s abnormality in relation to other children, they also preserve their own entitlement to knowledge about ADHD whilst undermining the entitlement of parents who do not know what it is like to have a child with ADHD.

Before and after claims: Managing stake

As we saw earlier in this chapter, stake management and, in particular, stake inoculation are used in the construction of factual description. Stake management is often a feature of before and after stories in which the ‘before story’ is shown not to have merit while the ‘after story’ is shown to be credible. The following extract provides such an example.

Extract 14, Gill and Mick

Gill: *it really and part of me thought ‘God I really shouldn’t say that’ because years ago maybe eight nine years ago and I’m guilty I I thought this ok and it was ok you read ...it must have been big about ten years ago it was always in the papers and it was it was the story that people were writing about ‘ADHD...’ and it seemed to be everywhere and lots of the newspapers and TV programmes at the time from memory very much focused on uhm ‘is ADHD a real condition? Or is it uhm is it an American thing?’ Because there seemed to be like a billion cases in America at the time uhm and and ‘is it just bad parenting?’ and I know that debate was going on then and I didn’t read too much about it because I didn’t have kids I was 21 and I thought oh ok it sounds like a you know you read a few excerpts and I said yes it sounds like bad parenting to me and I did*

probably think uhm think like that and it wasn't until later on when I was reading more of the scientific research and the ugh 'cos I don't believe things at face value me and M are very much hmmm...

Mick: *sceptical*

Gill: *we're sceptical and we read something in the paper and we'll forward it to each other and say 'can you find out the truth?' and we'll dig deep and we do to kind of myth bust*

Mick: *(laughs)*

Gill: *so I looked into a...ok actually I'm going to change my opinion*

In Extract 14, Gill outlines how ADHD was presented some ten years ago. She focuses on how the debate around ADHD centred on whether it was a **real condition** or **an American thing** or **just bad parenting**. Significantly, Gill aligns her former self with the sceptics **because years ago maybe eight nine years ago and I'm guilty I thought this ok ...** She is working up an account of how she was not pre-disposed to see ADHD as a medical category. In fact, she was sceptical of this new condition herself. Indeed, as she points out her original inclination was that ADHD sounded like **bad parenting**, which is very much a feature of psychosocial explanations for ADHD.

Having established her own alignment with the sceptics, Gill then undermines her own entitlement to knowledge (at that time). She depicts herself as only a vaguely interested, casual reader of the ADHD debate **I didn't read too much about it because I didn't have kids I was 21**. The inference is that her lack of engagement with the subject was partly the result of her youth and, perhaps, lack of experience with children; in turn, this lack of engagement and consequent lack of knowledge is constructed as the reason for her misinformed understanding of ADHD. In first aligning herself with the sceptics, and then dismissing her own

‘wrong’ understanding, she succeeds in undermining the knowledge claims of the sceptics (see Billig, 1996).

Gill’s description of her original lack of interest in ADHD as a medical category resonates both with Goffman’s (1990) description of the ‘normal person [...] becoming wise’ (1968:41) and also the discursive pattern ‘at first I thought, but then I realised...’ (see Chapter 4). This structure is often used to construct the rationality and neutrality of the speaker. The everyday common sense of the speaker is disrupted by unusual, but empirical facts. In this case, her naïve ignorance of ADHD is challenged and altered by the scientific evidence. As Gill points out once she read **more of the scientific research** she was able to declare with confidence that ***I’m going to change my opinion.***

Gill’s entitlement to make claims about ADHD is warranted because it is scientifically informed. Her own entitlement is worked up in contrast to the lack of scientific rigour of others. The other debates are represented as taking place within the popular media, rather than in the world of scientific research it ***seemed to be everywhere and lots of the newspapers and tv programmes at the time.*** Rather than scientists, she says people ***were writing about*** ADHD. The use of the word generalised ‘people’ here serves to undermine their entitlement to epistemological warrant (Potter, 1996; Sacks, 1995; Widdicombe and Wooffitt, 1995). They are not experts, they are just ordinary, uninformed people and, consequently, their knowledge is de-valued as it originates from unscientific sources.

Scientific knowledge is constructed by Gill as providing ***the truth about*** ADHD. It is through scientific knowledge that false claims (myths) about ADHD are eliminated. Gill describes how she and Mick ***kind of myth bust*** as they go about their quest for true, scientific understanding; they are sceptical of what they read in

the newspapers: ***I don't believe things at face value*** and prompt one another with questions such as ***can you find out the truth?*** In this before and after account of knowledge entitlement, non-scientific, popular misunderstandings are justifiably dismissed and replaced by a scientific explanation of ADHD. Again, resonating with the truth will out device, through the intervention of scientific knowledge, the truth about ADHD is revealed.

The rhetorical argument woven so far in this chapter has suggested that parents' descriptions of ADHD perform two discursive functions. The first part of this chapter looked at how parents' descriptions of ADHD construct it as an objective and scientific reality. It demonstrated that parents did this by putting forward biological and/or medical explanations. The second part of the chapter examined how parents undermined sceptical, alternative explanations of ADHD, specifically those explanations which invoked environmental, social and parental responsibility; features of a psychosocial repertoire.

These two distinct versions of ADHD can be understood as interpretative repertoires that can be used variably to perform the different functions described above (Edley, 2001a; Potter and Wetherell, 1987; Gilbert and Mulkay, 1984). The deployment of a biological repertoire and a psychosocial repertoire by the parents in this data set resonates with Horton-Salway's findings (2011) of newspaper media representations of ADHD. Significantly, as Horton-Salway suggests (2011), repertoires have a moral sense, and the parents in this data set are performing distinct rhetorical and moral work when they employ either of the two repertoires.

There is a danger, however, of setting up a dialogic polarity between these two repertoires, of suggesting that parents only draw on the biological repertoire in their accounts of ADHD and are always seeking to undermine the psychosocial repertoire. This would ignore the indexical, contingent nature of discourse (Taylor,

2001a, 2001b). As Heritage (1984) suggests, descriptions are not 'disembodied commentaries on states of affairs', they are chosen and consequential. Crucially, they are variable and will sometimes produce contradictory versions of events, which, as Edwards argues (1994:220) 'is a sign of construction and function processes at work'. The next part of the chapter looks at how the complexity of ADHD is constructed by parents and to what effect.

5.3 Constructing complexity

Extract 15, Gill and Mick

Int: ...you mentioned brain so I'm quite interested in how you attribute cause if you do for it

Gill: personally I know there's different research out there but I think it's I know there's a genetic link I'm not saying if your mum has it you have it but there's I think that genes uhm and susceptibility to things like that play a part and I think uhm [...] it's definitely genetic **Mick:** what's the expression? Bio-environmental?

Gill: it's a developmental it's a developmental uhm (tuts) disorder I can't think of another word but it's developmental

Mick: I think that's that's the nub of it but you know there's things that you do ... the environment they're in can influence to what degree ...

Gill: oh yeah absolutely and I think be... I think if we hadn't managed certain behaviours or picked up on it as well I think he could have... his symptoms... he might be placed on the high end of the scale and I think

Mick: high level really at the top

Gill: yeah and I think that because he's placed on the mild spectrum I really feel that's ...he's got this anyway...he's got this package he's got the n...you know (laughs) the neurological side he's got that...

Mick: *the thing is...*

Gill: *but we help and from such an early age*

Mick: *I think ...we must depend massively on the parents as well because you know some parents might might not be interested I mean I'm not saying that I've never been interested I'm very interested in his his I mean his upbringing and his uhm doing the best so I'm interested in ADHD from that point of view but if it wasn't for G's interest in the field in general we we wouldn't be where we are and I think G's been instrumental in really in his upbringing and I try to emulate what she does you know and...I mostly get it right [...] but even without understanding about what the condition is because as parents I mean even though I'm not interested in psychology because I want to get the best out of him and we see things working you know and I want him to have the best future he can have then then that makes a difference to his upbringing and his reactions and his outbursts whereas if we didn't care if we were just more interested in watching Coronation Street or whatever and let him get on with it then you know...*

Gill: *but I think parenting ...*

Mick: *...we'd think he was a bad boy...*

Gill: *...is has a big influence*

Alison: *that's really interesting you say that yeah [...] so it's ...there's a suggestion there that it's a mix that yes, ADHD exists but it can be kind of ...*

Gill: *amplified*

Alison: *amplified by parenting?*

Gill: *yes*

In Extract 15 aspects of the biological and psychosocial are both drawn upon by Gill and Mick to co-construct their account of ADHD. Gill, initially, draws upon distinct but very biological explanations for ADHD. She variously accounts for it in terms of there being a **genetic link**, it being a **developmental** disorder and her son having **the neurological side** of ADHD. Gill's biological accounting resonates with Raflovich's findings (2008:163) that parents deploy 'various and sundry' biological explanations in their descriptions of ADHD, reflecting the diverse biological accounts in the literature. Gill's explanations hinge on certain key scientific words: genetic, developmental, neurological, but these explanations are not elaborated on in any detail. This simplified version of expert knowledge provides an example of proto-professionalisation (Horton-Salway, 2004; Shaw, 2002); Gill has appropriated the biological lexicon and knowledge as her own. Mick also appropriates a scientific term to account for ADHD: **bio-environmental** and in doing so he introduces the potentially risky theme of the environment. So, in the first part of this extract, Gill and Mick account for ADHD in genetic, developmental, neurological and bio-environmental terms, which could be problematic; it being neither one thing nor another. However, Gill orients to this by describing her son's situation as **he's got this package** which permits the collection of items within one category, in an even more simplified version of expert knowledge.

Both Gill and Mick draw on expert, professional language when accounting for the causes of ADHD, which further establishes their entitlement to make knowledge claims. However, the introduction of **bio-environmental** raises the potentially problematic issue of the environment to the discussion about causes of ADHD. In acknowledging the influence of the environment on ADHD, both the scientific explanation of ADHD and also Mick and Gill's own position as parents could be threatened, especially, as they orient their explanation of environment to parental

influence. In this extract Mick and Gill manage to construct their own wider knowledge about ADHD without this prejudicing their position as good parents. Indeed, paradoxically, their acknowledgement of the impact of the environment, in fact, contributes, in this extract, to the construction of themselves as good parents.

At first, although Mick acknowledges environmental influence, he begins his account by stating clearly that Gill's biological explanations offer the fullest account of ADHD ***that's that's the nub of it***; clearly, he is not giving that up in favour of an environmental account. Initially, the impact of parenting is left vague as in the following statements: there's ***things that you do...the environment they're in can influence to what degree...*** (Mick) and ***if we hadn't managed certain behaviours and picked up on it as well*** (Gill) and ***but we help and from such an early age as well*** (Gill). This vagueness enables Mick and Gill to demonstrate their awareness (or knowledge) of current debates on ADHD without making explicit what these debates might be. Additionally, their vagueness, enables them to interpret environmental influence in a way that is constructive for them. They go on to construct a clear account of how their parenting has impacted on their child. Crucially, their son's ADHD remains as a given. Their parenting is not constructed as being responsible for this in any way. However, it is through their implied good parenting that the disorder was firstly recognised and then, successfully managed. Indeed, here, Gill constructs the impact of their parenting as having positive outcomes for their son; had it not been for their parenting, his ADHD would be more severe ***I think if we hadn't managed certain behaviours or picked up on it as well I think he could have ...his symptoms ...he might be placed on the high end of the scale.***

Mick develops this account of positive parental influence. He develops a description in which effective parental response is constructed as crucial to the

successful identification and subsequent management of ADHD. As with Gill's account, not once is parental behaviour constructed as contributing to the emergence of ADHD. Rather, the influence of parenting is constructed as vital with regards to recognising the disorder. As Mick says, he is *interested in* his son's *upbringing* and in *doing the best [...] if we didn't care if we were just more interested in watching Coronation Street or whatever and let him get on with it then you know [...] we'd think he was a bad boy*. Here, Mick constructs two categories of parents, those who are interested (as he and Gill are) and those who are not (those parents who watch Coronation Street). Mick suggests that it is good and interested parents who recognise and interpret their children's behaviour as not simply 'bad' but as biological/medical.

This section highlights the flexibility with which repertoires can be drawn upon. In this case, the psychosocial repertoire is used, not to negate or undermine the scientific explanation for ADHD, but to acknowledge the interplay between biology and environment. Crucially, in this extract, the successful negotiation of this interplay is constructed as being dependent on the skill of the parents. By constructing the complexity of ADHD, Mick and Gill not only demonstrate their wider, scientifically informed knowledge, which includes a potentially risky environmental explanation, but, in so doing, they manage to successfully construct themselves as good parents (a theme which will be taken up in the following chapters).

5.4 Summary

This chapter began by examining how parents' descriptions of ADHD constructed it as a scientific reality. It argued that parents' accounts of ADHD oriented to biological, specifically, brain and genetic explanations. Two ways of reifying the biological truth of ADHD were examined: first, the indexical construction of

abnormality in relation to normality and second, an account of the success of medication. The second part of the chapter examined how parents challenged and undermined sceptical views about the biological explanation of ADHD. Parents were shown to work up their own entitlement to epistemological warrant whilst undermining the warrant of people who held alternative views of ADHD. Parents' resistance oriented to those alternative views that accounted for ADHD in terms of lack of discipline, poor parenting and just 'normal' naughtiness. The final section of this chapter showed how parents work up ADHD as a complex category. In doing this, parents demonstrate a wide and expert knowledge base, and manage to both maintain the scientific account of ADHD whilst acknowledging their own, positive parental influence.

The parents in this study orient to two distinct accounts of ADHD: A biological account (the biological repertoire), and, one which suggests the impact of environment on the psychology of the child (the psychosocial repertoire). The availability of these contrary linguistic repertoires suggests an ideological tension between two competing versions of reality (Billig *et al.*, 1988; Gilbert and Mulkay, 1984). Each repertoire provides a very distinct account of a social category, and so, performs distinct rhetorical work (Billig, 2001). These findings support those of Horton-Salway (2011) with regard to media representations of ADHD. As she argues, in the case of ADHD, the repertoires offer distinct moral interpretations of the relationship between ADHD and parenting. It is therefore, perhaps, unsurprising that most parents work to construct the biological explanation of ADHD as the true one, which supports other research in the field (Horton-Salway, 2011; Bennett, 2007; Singh, 2004, 2003, 2002a; Malacrida, 2001). This biological repertoire, potentially, makes relevant very different subject positions for parents from those made available by the psychosocial repertoire, and both, in turn, construct very different identities for parents of children with ADHD. The next three

chapters examine how parents orient to these subject positions, Chapters 6 and 7 look at the gendered subject positions made relevant by and for mothers and Chapter 8, the subject positions made relevant by and for fathers.

Chapter 6 The blameworthy mother

6.1 Moral accountability and subject positions

The moral accountability of parenthood is identified in many studies. In Baruch's study (1981) of parents of children born with a physical disability, he argued they performed moral work in their accounts of their children's respective conditions, in particular, working to construct their parenting as morally adequate (see Silverman, 2001a). The moral accountability of parenthood is particularly acute with contested social phenomena such as ADHD as the different versions of such phenomena are implicated in the construction of subjects (Horton-Salway, 2011; Potter, 1996). For example, the two interpretative repertoires outlined in the previous chapter make available very different subject positions for the child, and the parents of children with an ADHD diagnosis (Horton-Salway, 2011; Gray, 2008).

Subject positions connect 'the wider notions of discourses and interpretative repertoires to the social construction of particular selves' (Edley, 2001a:210) and can be taken up or resisted (Terry, 2010). The take-up of one repertoire as opposed to another can be considered a moral evaluation 'because a commonly sensible alternative could also have been made' (Billig *et al.*, 1988:16). Regarding the two repertoires drawn upon by parents in this study, the biological/medical repertoire represents a child's, typically, troubling behaviour as a symptom of their medical 'abnormality', rather than the result of an ineffective or deficient social environment, suggested by the psychosocial repertoire (see Horton Salway, 2011; Blum, 2007; Singh, 2004, 2002a). Clearly, both repertoires have implications, not only for the way the child is represented, but also for the way that parents are positioned. A biological explanation of ADHD positions parents as 'free' of blame for their child's behaviour, while a psychosocial explanation makes relevant the

social environment, for which parents are, typically, responsible and so positions parents as potentially accountable for their child's behaviour. This and the following chapter examine how mothers accomplish moral adequacy through their take up of certain subject positions while Chapter 8 focuses on fathers.

Mothers, ADHD and moral accountability

The foregrounding of mothers in the literature relating to ADHD reflects the cultural positioning of mothers as the primary caretakers and caregivers of their children. As discussed in Chapter 3, within contemporary Western society, the gendered nature of caregiving means that mothers are held practically and morally responsible for the successful 'outcome' of their children (Blum, 2007; Gillies, 2005; Harden, 2005; Litt, 2004; McKeever and Miller, 2004). Within this ideology, it is understood that good mothers produce good children, and, therefore, mothers who do not have good children are judged not to be good mothers. This is particularly resonant for mothers of children with an ADHD diagnosis; children, whose behaviour is typically perceived as being disruptive and troublesome.

Existing research literature reveals that mothers' accounts of their experience of parenting a child with ADHD orient to themes of blame and judgement. Mothers report feeling blamed by professionals or other parents for their child's condition (Austin and Carpenter, 2008; Blum, 2007; Neophytou and Webber, 2005; Harborne *et al.*, 2004; Litt, 2004; Singh, 2004; Klasen and Goodman, 2000).

These accounts fall within a wider context of maternal blame, a context which makes available the prevalent subject position of the 'blameworthy mother'. Blum (2007) identifies this positioning of mothers as responsible for both 'good' and 'bad' child outcomes as a 'mother/valor-mother/blame' binary and it is certainly one to which the mothers in this data set orient in their talk.

This chapter will examine how mothers' accounts manage the blameworthy mother subject position and Chapter 7 will examine how mothers work to construct themselves as good (valorised) mothers, through accounts which make relevant abnormal or exceptional mother/child subject positions, and, conversely, through accounts which seek to normalise the mother/child subject positions. Although the data has been organised into these three strands (managing blame, constructing abnormality and constructing normalcy), they do at times, overlap. Locke and Edwards (2003:241) also identify three (very different) themes in their study of President Bill Clinton's talk in his Grand Jury testimony of August, 1998 and argue that 'speakers treat them alongside each other and in relation to each other, so that all three are somewhat alive in most extracts'. This is certainly true of the three analytic themes identified within the current study. Accounts of abnormal and normal mothering practices work to represent the speakers as good (valorised) mothers, and these, inevitably, also work to undermine the subject position of the blameworthy mother.

6.2 Resisting the blameworthy mother subject position

The moral tension that exists between the competing biological and psychosocial repertoires of ADHD is one that almost all the mothers in this study make relevant in their talk, in particular, in their accounts of diagnosis. Within this context of mother blame, it is understandable that mothers of children with ADHD draw upon biological explanations for their children's behaviour (Bennett, 2007; Blum, 2007; Singh, 2004) as this can work to absolve them of blame for their child's condition.

In this extract, Ingrid (supported by John) makes clear what is morally at stake for her and John with regard to obtaining a diagnosis and the competing explanations of ADHD.

Establishing what's at stake

Extract 1 Focus Group 1 (Ingrid and John)

Ingrid: *'It's clear he has ADHD there's no doubt about it he scored nine out of nine' whatever it is (laughs) uhm and he said 'you're doing fantastically there's absolutely nothing that you've done wrong' oh my God I walked out he said 'I'll give you medication'*

John: *it were like winning the lottery weren't it?*

Ingrid: *yeah*

John: *thank you thank you so much*

Ingrid: *we phoned everybody I phoned my mum I was like... I was in tears (unclear) I was like 'this is the happiest day of my life' and for most people...*

John: *sounds pathetic doesn't it?*

?: *no*

John: *it's not... it's such a hard slog to get actually where to get the help we got him the help he obviously needed [...]*

Ingrid: *yeah so relieved and somebody actually told us told us that 'you're doing a great job' he said 'you are fantastic'*

Alison: *mmm*

Ingrid: *and you just sit there and think 'really?'*

John: *after years of thinking 'it's your parenting and you're not up to scratch'*

This extract clearly illustrates how competing versions of ADHD are implicated with one another and do distinct moral work. At the beginning of Extract 1, the medical diagnosis is presented as unequivocal: ***'It's clear he has ADHD there's no doubt about it he scored nine out of nine'***. Here, Ingrid uses reported speech (Potter, 1996; Widdicombe and Wooffitt, 1995; Wooffitt, 1992) to provide

evidence of the medical professional's independent and expert opinion. The use of reported speech here confirms the objectivity of the diagnosis and corroborates the veracity of her and John's medical account of ADHD. Once the veracity of the medical explanation is established, then Ingrid, significantly, orients her talk to her and John's parenting: ***and he said 'you're doing fantastically there's absolutely nothing that you've done wrong'***. A medical explanation of their son's behaviour undermines alternative explanations, such as ineffective parenting. Again, Ingrid uses reported speech to provide independent witness to the 'fact' that she and John are doing a good job as parents, and not doing anything wrong.

For Ingrid and John (and other parents in this data set), a medical diagnosis provides a vindication of their parenting, and, unsurprisingly, perhaps, this is why relief is typically expressed. As John says, obtaining a medical diagnosis of ADHD ***were like winning the lottery***, which suggests an exceptional, joyful and life changing event. Indeed, the importance and significance of the diagnosis to Ingrid and John is illustrated by Ingrid's, perhaps surprising, claim that they ***phoned everybody*** and that it was the ***happiest day of my life***. Ingrid's use of the word 'everybody' and the superlative 'the happiest day of my life', is an example of an extreme case formulation (ECF, see Chapter 5), a device used to defend descriptions potentially at risk of being challenged. A diagnosis of ADHD for a child would not be a preferred option for any parent. In fact, possibly, it could be understood as the worst day of a parent's life, as Ingrid's unfinished sentence was presumably going on to say: ...***this is the happiest day of my life and for most people***... However, Ingrid's use of ECFs, even if understood as non-literal, illustrates her and John's investment in their construction of the day of diagnosis as being a really special day, a day which morally absolves them of responsibility for their son's ADHD diagnosis. The relief expressed by Ingrid and John at

receiving a medical diagnosis resonates with previous research (Neophytou *et al.*, 2005; Segal, 2001) and is commonly expressed by the other mothers in this study.

Blame and responsibility for their child's ADHD is also resisted by mothers through their descriptions of their children as new-born babies. As previously discussed in Chapters 2 and 5, psychosocial explanations imply that a poor nurturing environment contributes to the emergence of ADHD, and this clearly has implications for mothers, who are culturally positioned as the main caregivers. It is therefore, perhaps, unsurprising that mothers are keen to describe early indicators of 'atypical' behaviour in their children; sometimes, even within the womb, as this constructs ADHD as something intrinsic to the child, something within the child's 'nature' which confirms the biological explanation and, thus, undermines the environmental explanation. In addition, mothers, in describing their initial concerns about their child's behaviour, are also representing themselves as observant, and, therefore, morally good mothers. The following extract is an example of the dual function of such descriptions.

Constructing early abnormality

Extract 2, Paula (Focus Group)

Paula: *I knew the minute he could walk there was something I mean I knew there was something wrong when he was tiny when he was in his bouncer and things because he used to do some quite bizarre stuff but and he never cried for food and he never really made a fuss I mean he was a perfect baby in some ways because he never cried and he was quite content but he didn't like to be touched he didn't like to be picked up and things like that but looking back now and knowing what I know now I know why(?) but obviously at the time I thought there's something not right you just know and he was so different from my*

daughter so different so I did have that comparison because she hadn't been like that as a baby so...

In this extract Paula deploys both script formulation and breach formulation (Edwards, 1994) to work up a description of her son's 'abnormal' behaviour. In this case, script formulation is used to describe her son's behaviour as typical and routine (of him) and breach formulation is used to represent his behaviour as exceptional if compared to the norms of behaviour expected of a young child. The routine nature of his 'abnormal' (bizarre) behaviour is worked up through the use of the verb 'used to', which is used to indicate past habitual actions: **he used to do some quite bizarre stuff**. To legitimise the claim that her son's behaviour was bizarre, Paula provides examples of his behaviour **he never cried for food and he never made a fuss**. 'Never' is another example of an ECF, which, even if understood as non-literal, indicates Paula's investment in her account. Paula's use of 'never' builds upon the 'routine' nature of his bizarre behaviour indicated in her previous sentence, whilst also establishing the 'wrongness' of these reactions. As Edwards (1994) suggests, it is exceptional behaviour that typically needs to be accounted for. Non-exceptional behaviour is taken-for granted background knowledge, and does not need to be described; it is 'invoked through implication' (Edwards, 1994:222). Paula's assertion that her son **never cried for food and [...] never made a fuss** is constructed as exceptional and unusual behaviour to be contrasted with the implied norm that all babies cry for food and all babies make a fuss at times.

The robustness of Paula's description of her son's atypical behaviour is also strengthened by her use of a three-part list (see Potter, 1996), a rhetorical device which works to construct the listed items as being examples of a more general phenomenon. In this example, Paula says **he never cried for food and he never**

made a fuss and later ***he didn't like to be touched***. These three behaviours work as evidence of Paula's claim that her son's behaviour was bizarre.

Crucially, this abnormal behaviour is located firmly in the infancy of Paula's son. Indeed, Paula repairs her initial statement that she suspected there was ***something wrong*** when he started to walk to an earlier period ***when he was tiny when he was in his bouncer***. The locating of his 'abnormal' behaviour so early in childhood very much places ADHD within the child rather than within the child's environment.

However, despite locating ADHD within the child, mothers are still not entirely free from accountability and these accounts of children's 'atypical' behaviour are within longer narratives of struggle and battle to gain diagnosis. Resonating very much with Baruch's findings, (1981) the mothers in this study construct 'atrocities' stories (Silverman, 2001a; Baruch 1981) of late or inaccurate assessment and treatment of their child's condition by medical experts as exemplified in the following extract:

The attentive mother

Extract 3, Linda (Focus Group 1)

Linda: *I had the battle of getting anyone else to notice and when he was about two I started realising he was very different from the other children and went to the health visitor and she just used to say 'don't be so silly he's a lovely healthy boy' and I was like 'he doesn't say anything he's not interested in anyone else' and she just used to say 'oh that's nothing don't worry about it'*

As with Baruch's study, the mothers in this study represent themselves as mothers who were very much aware that their babies had problems prior to the diagnosis. Both of the previous extracts illustrate this. Paula reports ***I knew the minute he could walk [...] there was something wrong*** and later ***and obviously at the***

time I knew there's something not right you just know while Linda says *when he was about two I started realising he was very different from the other children*. As Silverman suggests (2001a:106), such accounts represent the mother as one 'who thoroughly monitored her baby but was spurned by the doctor'.

In producing these reports of maternal awareness, mothers construct themselves as morally adequate mothers, within a cultural context that suggests good mothers are vigilant and attentive to the needs and idiosyncrasies of their children. Paula's *you just know* appeals to a universally shared notion of motherhood, that suggests an essentialist quality of maternal instinct. However, despite the cultural, moral imperative to take up the attentive mother subject position, this subject position is also a risky one for mothers of children with ADHD to occupy.

Psychosocial explanations of ADHD make available representations of parents as being too quick to diagnose, or as inappropriately seeking medicalization of their child's behaviour in order to absolve themselves of responsibility (see Horton-Salway, 2011)

Mothers of children with ADHD, typically, therefore, find themselves in a double bind as to their moral accountability. Accounts of maternal attentiveness are mitigated by accounts which manage stake and interest (see Potter, 1996). As we saw in Chapter 5, parents' descriptions of their child's abnormality are constructed to resist possible understandings that they have an interest in obtaining a medical diagnosis. In Extract 2, Paula's claim that her son *was so different from my daughter, so different. So I did have that comparison because she hadn't been like that as a baby so...* is an example of stake management. Paula is showing that she is not blindly attributing abnormality to her son; she recognises 'abnormal' behaviour because she knows what 'normal' infant behaviour is.

Significantly, the normal behaviour she draws upon is that of her daughter. This again does rhetorical work in that it works to absolve Paula from responsibility for her son's condition. Paula's mothering cannot be held accountable for producing her son's atypical behaviour, because she is also the mother of a 'normal' child. This echoes with findings by McKeever and Miller (2004), who suggest that parents often draw on other siblings to provide evidence of their ability to raise 'normal' children, thus countering understandings that they may be responsible for producing pathology within the family.

The discussion of the above extracts suggests that mothers orient to the subject position of the blameworthy mother through their talk of diagnosis, specifically, in their accounts of relief at diagnosis, and also through their accounts of 'abnormal' behaviour being present in their child from a very early age, and, in some instances, from birth. The biological explanation of ADHD, legitimised by a medical diagnosis, locates ADHD firmly within the child rather than within the child's environment. However, several studies suggest that diagnosis does not necessarily remove mother-blame, but rather shifts it to other areas of maternal responsibility (Blum, 2007; Harborne *et al.*, 2004; Singh, 2004). This is supported by the accounts of the mothers in this study relating to medication.

6.3 The Problem of medication: Managing accountability

In Extract 4, Caroline sums up how mothers feel positioned within a 'no win' situation.

The judged mother

Extract 4, Caroline

Caroline: *and so... the other thing I think parents get with ADHD is uhm I think it's a label you can't win it's a label which is 'there's nothing wrong with them it's just the*

parenting' even with the label and I think when you've ...and if you medicate and the child then settles down there's a lot of negative judgement about medication [...] 'oh they just drug that child' so I think for parents you can't win

As many of the mothers in this study do, Caroline uses reported speech to construct herself as an object of judgement by others. Reported speech is deployed to represent some prior event which, as Benwell suggests (2012:367), may be 'generic, habitual, typified or even hypothetical'. Certainly, the fact that the two quotes in Extract 4 are not attributed to anyone in particular would indicate that they should be treated as emblematic of how Caroline considers other people to judge parents of children with ADHD. A longer discussion of the use of reported speech as a device to attribute accountability and responsibility appears later in the chapter, but for the moment, it is important to note that Caroline uses reported speech to illustrate how she feels judged as a mother, first, for being a, presumably, ineffective parent: ***'there's nothing wrong with them, it's just the parenting'*** and then, post-diagnosis, for medicating her son. In conveying the attitude of the unnamed speakers, she selects the word 'drug', rather than the more morally, neutral 'medicate' ***'oh they just drug that child'***. Extract 4 follows on from a longer description (Extract 5) in which Caroline provides accountability for opting for the medication route. After offering such an account, Caroline is immune from the criticism that she has simply 'drugged' her child, and, consequently, the 'people' who make such statements are undermined as ignorant and callous in their dismissive judgement.

Justifying medication: Before and after stories

Extract 5, Interview with Caroline

Caroline: *he's exhausting I mean physically and mentally exhausting to be at home with a boy who's got a concentration span of about 2 minutes and he was very*

damaged when he got home we had huge huge meltdowns massive anxiety uhm that I by that stage was pretty skilled and I knew what I was doing so I was able to work with him very intensively to try and you know bring down his anxiety and the other thing I did was I went straight from this side and said 'I want this child on medication' and I went privately to a consultant that I knew was really good ...is one of the leading people in the field [...] and I said 'please do an assessment' he agreed and immediately put him on medication and the transformation was unbelievable [...] completely changed his life overnight on the first dose within half an hour

Alison: *really?*

Caroline: *40 minutes ok (smiles)*

Alison: *(laughs)*

Caroline: *he had transformed [...] and he was like a different child and suddenly he was able to focus and he could learn*

In Extract 5, Caroline's description of her son before and after medication manages her accountability for choosing to medicate him. Caroline works up an identity of her son which justifies her decision to medicate. His behaviour is described as extreme: **very damaged [...] huge huge meltdowns [...] massive anxiety** and the impact on her and her family is manifest: **he's exhausting I mean physically and mentally exhausting**. To counter any possible suggestion that medication was sought by Caroline to make her life easier, she works up her own identity as a skilled mother who could cope with her son's behaviour. She provides an account of how, actually, she was managing the situation and was not overwhelmed by it **I, by that stage, was pretty skilled and I knew what I was doing so I was able to work with him very intensively to try and you know bring down his anxiety**. She was not an overwrought mother looking for a 'quick

fix' to manage her son's behaviour. Similarly, her choice of consultant was considered and responsible ***I went privately to a consultant that I knew was really good...is one of the leading people in the field.***

Having countered possible doubts about her own motivations in seeking medication, Caroline proceeds with the 'before and after' story of her son's transformation. The transformative effect of medication is described as ***unbelievable*** and immediate; [it] ***completely changed his life overnight on the first dose within half an hour.*** Again, Caroline uses extreme case formulations in her account. Although Caroline's claims about the immediacy of the effect of the medication shift from it being overnight, to half an hour, to (later) 40 minutes, this does not dilute the effect of her description. As Edwards (2000) suggests, the nonliteral nature of ECFs is not problematic, but demonstrates an investment in a position taken. This is, perhaps, evidenced in Extract 5 at the point where, after Caroline has said that medication changed his life within half an hour, the interviewer responds ***really?*** This could, perhaps, have been understood as a challenge to Caroline's claim. However, Caroline smiles, and alters the timing to 40 minutes, a remarkably short time span to experience a 'life-changing' event. The factual detail is not significant; it is the rhetoric function of these expressions that is. Caroline's account works as a way of indicating that this information should be treated as *if it were* factual. The immediate transformative effect of medication is worked up as proof of the legitimacy of medicating. Ultimately, medication is justified through its dramatic and visible success. The behaviour of Caroline's son after medication is described in stark contrast to the behaviour prior to medication: ***suddenly he was able to focus and he could learn.*** Interestingly, as many of the mothers do, Caroline makes relevant the subject position of the achieving schoolchild (boy) in accounting for her decision to medicate, which arguably, also makes relevant the subject position of the good mother, who bears responsibility

for their child's outcomes and anticipated futures (Weusten, 2011; Blum, 2007; Backet-Milburn and Harden, 2004; McKeever and Miller, 2004).

Before and after stories are a robust discursive phenomenon, used in many contexts to perform certain types of rhetorical business (see Horton-Salway, 2001). In Caroline's example, the contrast between the horrific situation detailed in the 'before' account and the optimistic current situation serves to inoculate her from a hostile response to her medicating her son.

Rachel's account in Extract 6 reveals similar concerns regarding the immediate transformative effect of medication: ***it was instant***, and again, justification for medicating her son comes from his being more productive at school: ***he was concentrating he was calmer he was uhm his learning went up like this in terms of where he was meant to be academically***. In addition, Rachel also attends to issues of agency, which features in several of the mothers' accounts of medicating their children.

Constructing agency

Extract 6, Rachel's Interview

Rachel: *so the diagnosis was sort of mild ADHD they always talked at school uhm around it and after that we spoke about medication we spoke about the options we spoke about the risks spoke about the best one for him uhm and we had a trial of it and there was all these uhm people are very ...have very strong views on whether medication is good or not good and I think she sort of uhm I was... going to ...talk us into but that wasn't the fact at all cos it was entirely our decision but she gave us enough information that took away all the scare and went through all the potential side-effects and the thing that swung it for us was that she said it's not addictive which it isn't it's not addictive and if you*

have a side-effect they're reversible so if you take a side-effect and you get a tick which is one of the things you can get you stop taking it the tick will go so there didn't seem to be any risk in trying

Alison: *no no*

Rachel: *and we started off on 10 mgs the school said 'no' [...] we tried 20 no 30 yeah it was instant*

Alison: *oh really*

Rachel: *well instant in that the moment the dose was right the difference they saw in him was phenomenal*

Alison: *yes yes and it ...he was able to...*

Rachel: *he was concentrating he was calmer he was uhm his learning went up like this in terms of where he was meant to be academically around there you know we still have issues around concentration now and we're not sure now he's bigger whether the dose is right and all of that so there's... it's ongoing issues really but at the time you'd see the same teacher day in day out was brilliant*

Alison: *so it was the right decision*

Rachel: *it was absolutely the right thing he's very small and it does affect your appetite that was the only thing we had and that was a problem so they're still measuring him and weighing but he doesn't have it at weekends doesn't have it holidays so so far it hasn't affected him because it can affect your growth can't it? [...] he's he's he's two years older now than he was when he went on this dose and uhm we've got an appointment with the doctor in a few weeks*

From a discursive perspective, a focus on agency is not concerned with *whether* Rachel is really making choices and acting upon them, but to *what rhetorical effect* her claims to agency are accomplishing. The agentic 'self' is very much implicated

with notions of responsibility. As Burr says (2003:147), agency is 'constituted in the accounts that we give of our actions, the way we represent ourselves as responsible for, or not responsible for, our behaviour'. Claims of taking responsibility (or surrendering responsibility) are morally charged in that they implicitly provide explanations of, or justifications for, a course of action (see Holstein and Gubrium, 2000). Discursive practice around agency is particularly significant within talk relating to medical issues. Talk about illness is ideological and dilemmatic (Radley and Billig, 1996) and, in particular, it can reveal the tensions between prevailing cultural notions of expertise and equality (Billig *et al.* 1988). As Bishop and Yardley (2004) argue, talk about decision making in relation to medical matters can reveal how (medical) authority and expertise conflict with the ideal of individualism and personal autonomy and agency. They argue that, typically, the doctor/patient relationship is socially sanctioned and, thus, not to take-up medical advice is irresponsible. Therefore, descriptions of autonomous decision making need to be morally accountable.

Rachel's account of how she (and her husband) came to medicate their son reveals the tension between expertise and autonomy. The authority of the medical expert ('she' in the extract above) is conveyed by descriptions of how she passed on her knowledge; she is the one who owns this knowledge and has the power to convince Rachel and her husband to opt for medication ***she gave us enough information that took away all the scare and went through all the potential side-effects and the thing that swung it for us was that she said it's not addictive, which it isn't, it's not addictive.*** In this description, Rachel represents herself as a worried (scared) and uninformed parent, who turns to the medical expert for help in making her decision. Similarly, at the end of this extract we learn that Rachel is intending to go back to the doctor to seek advice about increasing her son's dosage.

Despite making relevant the medical expert subject position, Rachel's account attends very closely to issues of agency. Indeed, she draws attention to the tension between authority and personal autonomy herself: ***I think she sort of uhm I was...going to...talk us into but that wasn't the fact at all 'cos it was entirely our decision.*** The implication suggested by Rachel's account is that they initially attended the clinic with the expectation that medical authority would prevail, but that, in fact, the doctor handed over the decision to medicate to them. This is an example of the discursive pattern 'at first I thought, but then I realised' (for example Sacks, 1995). This is an interesting construction of agency. Clearly, Rachel and her husband could not medicate without the doctor's sanction, and, ultimately, doctors can override decisions made by parents. In this example, the construction serves to highlight that the doctor was treating Rachel and her husband as responsible parents; they were given the choice to medicate, presumably, because she found them to be responsible parents.

Agency is also displayed through the change in footing (Goffman, 2001). Rachel moves from the role of animator, in which she describes and reports what the expert told her and her husband ***she gave ...went through...she said...*** into the principal role, in which the advice now is seen to emanate from her. The change of footing occurs with the use of the relative pronoun 'which' (underlined) in the following example: ***she said it's not addictive, which it isn't, it's not addictive and if you have a side-effect, and you get a tick, which is one of the things you can get, you stop taking it, the tick will go.*** As Goffman argues, footing has implications for accountability. The animator is understood as merely 'passing on' information, whereas the principal is understood to be invested in the stance articulated. In her role as principal, Rachel is demonstrating her awareness of the potential side-effects of medication and moves from being a passive 'receiver' of

medical knowledge, to an informed and responsible manager of her son's medical condition.

As discussed in Chapter 3, existing neoliberal, political ideology emphasises the notion of 'responsibilisation' (see Rose, 1999) and, specifically, of 'good' parenting to the production of 'good' citizens. There is a moral imperative for parents to assume responsibility for their children (Ribbens McCarthy *et al.*, 2000). This moral imperative is especially strong for mothers as the culturally specific, gendered nature of caregiving positions mothers as primarily responsible for their children's well-being (Weusten, 2011; Blum, 2007; Doucet, 2006; Harden, 2005; McKeever and Miller, 2004). Even within the socially sanctioned doctor/patient relationship, mothers are held accountable for decisions made for/or on behalf of their children. This is particularly true for mothers of children with ADHD.

Psychosocial explanations of the condition represent parents as self-serving, even abusive in allowing their children to be medicated. Although medical diagnosis partially absolves parents from responsibility for 'causing' their child's condition, shared responsibility for children's medical welfare is a moveable discursive phenomenon; at any point responsibility can shift from the doctor to the parent. Parents (mothers) remain morally accountable with regard to their child's ongoing medical treatment. It is this moral accountability that mothers are orienting to in their local construction of agency. However, as Bishop and Yardley (2004) indicate, taking agency in treatment decisions is potentially risky as shifting from the patient to the agent position involves being held morally accountable for one's (in this case, the child's) health.

Mothers attend to this complex positioning in their accounts of how they 'fine-tune' their children's medication. Resonating with existing literature (Taylor *et al.*, 2006; Neophytou and Webber, 2005; Singh, 2005; Litt, 2004), Rachel, as many of the

mothers in this study do, makes relevant issues of agency with respect to 'medication breaks' and the 'fine-tuning' that mothers undertake ***he's very small and it does affect your appetite that was the only thing we had and that was a problem so they're still measuring and weighing but he doesn't have it at weekends doesn't have it holidays so, so far it hasn't affected him because it can affect your growth, can't it?***

Accountability for managing their children's medication is provided in accounts which orient to the potential risks of medication. In particular, several of the mothers in this study express concern over loss of appetite, consequent weight loss and the effect of medication on growth. As responsible mothers, they represent themselves as informed with respect to the risks, and take action to mitigate these potentially harmful effects by taking 'medication holidays', or even by 'tweaking' the prescribed dosage of drug. Although Rachel's claim that ***we started off on 10mgs, the school said 'no', [...] we tried 20, 'no', 30 'yeah'*** is somewhat ambiguous with regard to how much expert medical involvement there was in these decisions to change the amount of medication, it was common for these mothers to talk about increasing or decreasing prescribed dosages without seeking prior medical permission. Unlike other patients, who demonstrate agency by not taking medical advice and are, subsequently, positioned as irresponsible, accounts of agency by these mothers function rhetorically to position them as 'good' mothers who assume responsibility for the management of their child's illness.

Agency, however, is not always constructed as the responsible course of action. The dilemmatic nature of the relationship between agency and medical authority is revealed in Ingrid's defence of medication in Extract 7.

Constructing medication as the morally right thing to do

Extract 7, Ingrid (and John)

Ingrid: now I think I'm the other way you...watch these programmes with people who'll refuse to medicate and I think that's completely wrong now because you see that even though it's medication they do need it because they are ...you know ...there's not the right connection up here (laughs)

In this extract, Ingrid distances herself from those 'people' who act autonomously and choose not to medicate: **people who'll refuse to medicate**. The word 'refuse' has a rhetorical impact as it implies a stubbornness, which the more neutral 'choose not to' (for example) does not. In fact, combined with the modal 'will' (which here suggests persistent insistence), 'refuse' suggests a problematic form of agency. This is particularly true in relation to the context of refusing prescribed medication. The 'giving' of a prescription carries a certain moral imperative about what needs to be done. Indeed, Ingrid goes on to assert that she thinks such decisions are **completely wrong now**. The use of the word 'now' is an interesting one. The implication is that Ingrid did once align herself with parents who refused to medicate (she was prepared to act autonomously if need be), but has given that position up for a 'better' one. Displaying a previous alignment with a now criticised position (here the refusal to medicate) works rhetorically to strengthen the criticism and undermine the previously held position (see Billig, 1996).

It also (again) resonates with the discursive pattern 'at first I thought, but then I realised...'. As defined in Chapter 4, the everyday common sense of the speaker is disrupted by unusual, but empirical facts. The empirical objectivity of ADHD is established by Ingrid **even though its medication, they do need it because [...]** **there's not the right connection up here**. In constructing the objectivity of ADHD as a medical/biological fact, Ingrid removes the necessity for any autonomous

action. Medical problems necessitate medical solutions. Authority and accountability lie with medical expertise and not with parents; there is not a choice to make. In this instance, the exercise of agency by parents who refuse to medicate is rhetorically pitted against the authority of the medical repertoire and is constructed as morally problematic.

So far, this chapter has discussed how mothers resist the blameworthy subject position through their take up of the biological repertoire and through descriptions of how they manage accountability for the decisions they make. They do this through their accounts of relief at diagnosis, their descriptions of their early acknowledgement of abnormality and difference in their children, and through descriptions of accountability relating to medication, in particular, through their concerns around agency.

However, mothers do, in one sense, also engage with the position of blameworthy mother; not in the sense of accepting blame or responsibility for their children's condition, but through their accounts of isolation and victimhood. Paradoxically, the blameworthy mother also makes relevant the subject position of the 'victim mother', victim, in particular, of other people's scrutiny and judgement.

6.4 Constructing a victim identity

As discussed in Chapter 4, within a discourse approach, identities are not static or stable, but are flexible, and shift depending on the context in which they are being produced and on the discursive work being done. In this study, mothers, at times, construct themselves (and their families) as victims, and at other times as 'fighters' and advocates for their children. The construction of victimhood is a rhetorical device which can work to gain sympathy and secure support for the subject position (Zvering, Stam and Babins-Wagner, 2011). However, it is also a risky subject position to occupy, as it can reproduce repertoires of blame, and stigma.

As Zvering *et al.* (2011:2388) state, 'it is not surprising that identity work of conversation participants involves a delicate balance in which victim identities are both embraced and resisted'.

This section examines how mothers embrace and resist the victim identity and to what discursive effect. It will firstly discuss what is accomplished by constructing a victim identity for themselves and their families. It will then consider how the context of victimhood justifies and provides accountability for mothers' descriptions of resistance and 'battle', in particular with regard to the constructed victim identity of their children (sons).

Extracts 8 and 9 are typical of several of the mothers' accounts of victimhood located in the school playground. Both extracts feature accounts by Julie; the first account is taken from the focus group, where the victim identity was made relevant by all of the participants in the group. The second account comes from the one-to-one interview conducted with Julie.

Constructing the horror of social situations

Extract 8, Focus group 1 (Julie and Ingrid)

Julie: *and I used to stand in that playground and I'd I'd rather die than sit in that blinkin' playground and I'd try to stand behind the apparatus or shuffle over to a tree cos I just thought 'I can't bear them' 'I can't bear them' most of them are new it's their first borns in the class with C (name of child) and I just thought 'you know nothing' (laughs) you're amateurs the lot of you so that was C [...]*

Ingrid: *that's where people are all eyeing themselves up it's a horrific place to go*

Extract 9, Interview with Julie

Julie: *yeah very much so yeah I used to dread dread I can't tell you how much I used to dread collecting him I tried all ways of like being the first one in the queue like running with him to being the last one in the queue I even sent T in (laughs) to (unclear) because she would just be ready and waiting with a big list of things that he'd done wrong*

Accounts of social isolation and the avoidance of social situations feature frequently in the literature relating to mothers and ADHD (Berman and Wilson, 2009; Gray, 2002b), as they do in the accounts of mothers within this study. Strong and emotional language is used to construct the horror and pain of social situations, in particular, of the school playground. Julie's language is extreme and emotive: in Extract 8, the horror of the school yard is constructed through her claims that ***I'd rather die [...] I can't bear them*** and is supported by Ingrid's assertion that ***that's where people are all eyeing themselves up, it's a horrific place to go***. The ECFs work to counter possible challenges to the legitimacy of Julie and Ingrid's claims that the school yard is a horrific place to go. Similarly, in Extract 9 Julie invokes her dread of entering the school playground to collect her son at the end of the school day. ***I used to dread, dread, I can't tell you how much I used to dread collecting him***. The word 'dread' invokes fear and pain and serves as a juxtaposition to the seemingly mundane and routine activity of collecting her son from school. Encountering others is a painful hurdle she has to endure or avoid. Julie describes the strategies she employs to avoid other parents (in Extract 1) ***I'd try to stand behind the apparatus or shuffle over to a tree*** and the headteacher (in Extract 2) ***I tried all ways of like being the first one in the queue like running with him to being the last one in the queue***. Julie's accounts of the school playground are horrific and poignant and work to position

her as a victim who experiences pain and humiliation as a result of her son's disorder.

This resonates with Goffman's concept of courtesy stigma (Goffman 1990), which, existing literature suggests, mothers experience in relation to their ADHD children (Harden, 2005; McKeever and Miller, 2004; Gray, 2002a, 2002b), in particular in public spaces and situations (Ryan, 2006), such as school playgrounds, where parents' competence is most likely to be subjected to scrutiny and judgement.

Identities are not constructed in isolation but often derive their meaning from their binary opposite. A victim identity is typically positioned in relation to a perpetrator identity. Indeed, victims do not exist without perpetrators. In the extracts above, the parents and teachers who scrutinise Julie are constructed as the perpetrators of Julie's dread of the playground. Crucially, these accounts of victimhood are, typically, worked up through descriptions of the perpetrators or the perpetrators' behaviour, which is often represented as extreme, unfair and, therefore, morally questionable. Accounts of victimhood are, therefore, rhetorically significant as the positioning of perpetrators as morally ambiguous or inadequate, in turn, positions victims as morally righteous. The victims in these accounts can be understood as good mothers, the perpetrators, as bad mothers (parents). Thus, constructing a victim identity can be understood to be doing moral work. The construction of victim/perpetrator identities is accomplished through the use of several discursive devices, including membership categorisation device (see Sacks, 1995, Stokoe, 2003, 2009), the objectification of complaints (see Edwards, 2005) and active voicing, or reported speech (see Benwell, 2012; Parker and O'Reilly, 2012; Johanson, 2011; Stokoe and Edwards, 2007; Buttny and Williams, 2000), examples of which appear in the following section.

In Extract 10, the perpetrators are constructed as those parents and professionals who (falsely) accuse Donna and her son of being involved in various troubling incidents. Their 'morality' is called into question through Donna's formulation of the unfair treatment she and her son had to endure. Donna then goes on to construct her own morally accountable identity by positioning it in relation to the category of single mother.

Constructing the perpetrator: Morally ambiguous categories

Extract 10, Donna

Donna: *...I've had parents knocking at my door; that I've had to report to the police for an incident that L wasn't even involved in but I never even got an apology. There was another little boy in the school that apparently self-harmed himself and then took an overdose of tablets this little boy was eight I was called into the school about this little boy who committed tried to commit suicide and the headteacher said to me that the psychiatrists at the hospital have been talking to this little boy and uhm what's come out that is that L is saying to him 'oh my writing is better than yours' which I can't see as being true because L lacks confidence he's the worst in the class as far as he's concerned but apparently he'd said all this to this little boy and this is what caused this little boy to take this overdose and 'when he comes back to school we're expecting L to change his attitude', I mean I was sat there in a flood of tears (laughs)*

Alison: *oh,*

Donna: *Now, I mean this little boy that they were questioning me about he came from a broken home the mum was single not that I'm anti that but the background was totally different and they're calling me in blaming me*

In this extract, Donna is providing detailed account of the accusations that are made against her and her son. In the first example, Donna's description of the manner in which the accusation was made contributes to its construction as unfair and unreasonable. The use of the construction 'have somebody doing something', as in *I've had parents knocking at my door* implies a persistent and unwanted action. The structure is often used when describing unsolicited, or, even unwarranted behaviour that has an impact on the subject. The 'ing' form suggests a repeated and dogged action (rather, than, for example 'I've had parents knock at my door'). The choice of lexis also works to formulate the parents as vaguely threatening and intrusive. *Knocking at my door* invokes 'noise', potential anger, and it invokes a 'physicality' that 'ringing my doorbell' or 'calling round' does not. Similarly, the use of the word 'door' also invokes an intrusion into Donna's domestic life. The front door is a symbolic boundary between the public, potentially, threatening environment and the safe, domestic environment. Through invoking the relevant category environment 'home' (see Stokoe, 2003), Donna begins to make relevant the good mother position. Indeed, she goes on to work up a construction of herself as a morally accountable, good mother, who is the victim of 'bad' parents' intrusion into her private, domestic space.

This extract continues with an account of how Donna's son is implicated, by the professionals, in the attempted suicide of another schoolboy. The professionals' account of what happened, that her son's comments had triggered the suicide attempt, is formulated as highly doubtful by Donna. Her repeated use of 'apparently', works to cast doubt on the facts reported: the boy is said to have *apparently self-harmed* and her son is reported to have *apparently [...] said all this [...] and this is what caused this little boy to take this overdose*. Donna's undermining of the accusations against her son is strengthened by her claim to epistemological warrant (see, for example, Sacks, 1995). As his mother, she is

entitled to claim with authority that the accusations made about her son [she] **can't see as being true because L lacks confidence, he's the worst in the class as far as he's concerned**. Drawing upon her experiential knowledge of her son adds to the robustness of Donna's account that the claims against her son are unfounded.

Having undermined the integrity of the accusations against her son, Donna further works to morally position herself in relation to the mother of the boy against whom her son was said to have acted spitefully. Donna does this by drawing on the socially and culturally available category of single mother to perform moral work. Membership categorisation makes available a stock of common-sense knowledge about a specific category, which, although drawn from the wider socio-cultural context, is of relevant concern within the local interaction (Stokoe, 2009, 2003; Sacks, 1995; Wooffitt, 1992). As identified by Sacks (1995), categories are inference rich, and, as such, category-bound activities, rights and obligations (Stokoe, 2003) are implicated within each category. Categories are also hierarchical in their relation to one another. For example, Stokoe's (2003, 2009) work on neighbourhood complaints indicates that, women's relationship status is regularly invoked as a resource when complaining (and when justifying complaints). Typically, categories such as 'the single mother' perform moral work because they are drawn upon to infer a breach of the moral order. As Stokoe suggests (2009), the term 'mother' forms part of the standardised relational pair (SRP), mother and father, the combination of which is the culturally sanctioned, heteronormative construction of what a 'good' family is. Donna makes relevant the hierarchical nature of categorisation in her statement: **Now, I mean, this little boy that they were questioning me about, he came from a broken home the mum was single, not that I'm anti that but the background was totally different, and they're calling me in, blaming me**. Donna's own membership of the

category mother is, thus, embedded within the implied relational pair of mother-father, and is inferred to be morally superior, hence her righteous indignation that she is being called in by the headmaster to account for herself, whereas, the 'single mother' is not. In this instance, the morally ambiguous category 'single mother' is drawn upon to formulate Donna's position as a morally adequate, good mother, who should not be required to account for her parenting.

Moral (in)adequacy and victim/perpetrator identities are further invoked through accounts of rejection by friends or acquaintances. In the next two extracts, the behaviour of these friends is worked up as warranting of complaint.

Building complaints about others: the recurrent pattern of rejection

Extract 11, Paula

Paula: *...and you lose lots of friends or well what you think are your friends cos they don't want your child around their house because your child wrecks their house so well we just won't see each other and you do you feel it, it is really hard*

In this brief extract, Paula formulates her friends' rejection as a generalised and recurrent pattern. The use of the generalising pronouns 'you' and 'they' works to construct these events as habitual; one instance of many (Benwell, 2012; Stokoe and Edwards, 2007). 'You', in particular, also appeals to a shared, common-sense, understanding, which makes the deniability of the account difficult. In formulating these friends' actions as 'scripted', that is, normal and routine (see Edwards, 1994), the locus of Paula's implied complaint resides very much with them, rather than it being heard as originating from her own disposition to complain (Edwards, 2005).

Emotion discourse is also, very subtly, invoked to position Paula as a victim of her friends' unfeeling and casual rejection. Paula's initial ***you lose lots of friends or***

well, what you think are your friends... suggests a betrayal of trust, and an underlying disappointment. Indeed, Paula goes on to reveal her hurt and confirms that ***you do feel it, it is really hard***. Once again, Paula's use of the generalised particle 'you' works to build affiliation between the speaker and listener and implies that her emotional response is a shared and common-sense one. As Locke and Edwards (2003) point out, emotion talk is deployed in the production of actors' general dispositions and also in social accountability. In this short extract, a difference in dispositional attributions between Paula and her friends is suggested. She says of her friends ***they don't want your child around their house because your child wrecks their house***. Paula's loss of friendship is accounted for in relation to the concerns of her (generalised) friends about their houses, which in turn works to represent them as somewhat casual and shallow. This construction of Paula's friends as careless in their rejection of Paula can be contrasted with her own stoical acceptance of this rejection: ***so, well, we just won't see each other***. Paula's resigned acceptance of this situation works to position her as the passive recipient (the victim) of others' arbitrary whims and judgements (the perpetrators); she has no other choice. It is significant that in this poignant and potentially very upsetting account of rejection, Paula does not once use the personal pronoun 'I'. In using generalised pronouns, Paula works up an account of common-sense and appropriate emotional responses, whilst also maintaining a personal distance from the account worked up. This emotional distance also performs identity work in that the rhetorical effect of Paula's account establishes her as rational and 'properly' behaved (see Locke and Edwards, 2003). By keeping an emotional distance from her account, Paula succeeds in distancing herself from any implication that it is her own behaviour that might be the source of her friends' rejection. As with all of the mothers in the following examples, she is the victim, rather than the perpetrator of trouble (Stokoe and Edwards, 2007).

Extract 12 comes from the second focus group. This extract starts with Jane's account of rejection by a post-natal group. Similar to Extract 11, it works up the objectification of her complaint, that is, that her complaints about the behaviour of the post-natal group are warranted by their actions. As the extract continues, the warrant of the complaint is strengthened by contributions from other members of the focus group. This extract works, therefore, as a joint production of a complaint against generalised 'others'; others being those that judge and blame mothers (parents) for the behaviour of their ADHD children.

The socially ostracised mother: Reporting the words of the perpetrators

Extract 12, Jane, Gill, Alan, Rachel, Mick

Jane: *I got asked not to go back to the post-natal group I was six months pregnant with our second one and uhm a few of the mums had obviously had a chat when I wasn't there and one said to me who was a close friend of mine at the time well I thought she was and she said 'uhm a few of us have been chatting and think it's best that you don't come back'*

Voices: *gasps*

Gill: *that's bad*

Alison: *that's awful*

Alan: *yeah no support at all*

Rachel: *that's horrendous*

Jane: *'you know you don't seem to be able to keep him under control at all' and even though I'd*

Alan: *you know it was 'real bad parenting' type of push on you wasn't it*

Jane: *and it's really sort of it sticks with me now cos I see this parent every day at school [...] this was sort of someone who'd been with me since months old up to*

about 3 and you know just sort of ostracised me and then I was getting worried thinking 'oh gosh' you know there we were in a group of about ten of us and then I didn't mix with any of them for a long while because I just thought I dread to think what they think of me really

Alan: *well you just went back into yourself didn't you?*

Jane: *yeah*

Rachel: *you don't need that judgement people are very quick to judge*

Voices: *supportive noises*

In using the passive construction ***I got asked not to go back***, at the beginning of the extract, Jane makes relevant a victim identity; victim in terms of being the passive recipient of others' judgement and sanctions. The decision not to return to the post-natal group was not one that Jane initiated or was privy to, but was a decision presented to her by the others in the group. The unreasonableness of this 'request' is strengthened by Jane's revelation that she was six-months pregnant at the time. Jane is, arguably, making relevant the membership category 'pregnant woman', which carries with it the common-sense inference that pregnant women are more 'vulnerable' than usual. As with the previous extract, the rejection is worked up as unanticipated through the involvement of Jane's 'supposed' friend: ***...a close friend of mine at the time, well, I thought she was*** and works to suggest a betrayal of Jane's faith in her friend. Victimhood can be seen to have a rhetorical function here (see Jansen, 2000), as it depicts Jane as the innocent, perhaps naïve, victim of others. In constructing her own passive, victim identity, she also formulates the other members of the post-natal group as callous and somewhat bully-like in their behaviour. Jane's understated description of how the group came to the decision: ***they obviously had a chat when I wasn't there*** works both as an indictment of their 'cowardly' behaviour; they decided this when

she was not present to defend herself, and also to distance herself emotionally from the account. As with Paula in the previous extract, Jane does not, in this instance, explicitly express anger or hostility or upset towards the perpetrators but remains almost as a neutral, detached reporter of events. Again, this works to remove any suggestion that Jane's implied complaint about the behaviour of this group should be understood as emanating from her own disposition to complain and overreact to situations.

Jane's detachment from what she is describing is further exemplified in her use of reported speech: ***she said, 'uhm a few of us have been chatting and think it's best that you don't come back'***

The role of reported speech, particularly, active voicing, in rhetorical, moral and identity work is well documented (Benwell, 2012; Johansen, 2011; Stokoe and Edwards, 2007; Goffman, 2001; Buttny and Williams, 2000; Bakhtin, 1986).

Reported speech is understood as a 'phenomenon of heteroglossia or double-voiced discourse that 'serves two speakers at the same time and expresses simultaneously two different intentions' (Bakhtin, 1981:324). Reported speech works to produce and reproduce the identity of both the current speaker and the reported speaker as well as adding to the factuality, and, thus, robustness of an account (Benwell, 2012). In this instance, Jane's use of reported speech works to disassociate her from what is said; the audience is shown rather than told what happened, and the audience is invited to make inferences about the reported speaker, who is held socially responsible for what is said. Used frequently in complaint narratives, direct speech is used to locate the complaint in the other party (Benwell, 2012; Stokoe and Edwards, 2007; Buttny and Williams, 2000), and not in the speaker's disposition to complain. The audience's responses to Jane's use of reported speech indicate their orientation to an expectation that this

conversational turn requires a moral assessment of the reported speaker's actions. Responses such as ***that's bad [...] that's awful [...] that's horrendous*** are all offered as morally indignant condemnation of the event, and Jane's account of her marginalisation remains robust and her moral integrity remains intact.

The moral integrity of other mothers is questioned by holding them socially accountable for the actions conveyed. Descriptions of the emotional effect experienced by the current speakers provides evidence of the impact of the actions against them. The account of emotional effect experienced by Jane is jointly produced by her and her husband Alan. Jane's use of the word 'dread' in ***I dread to think what they think of me really***, as with Extract 9 invokes fear, pain and anxiety. Emotional effect is further worked up by Alan's appeal to Jane that ***well you just went back into yourself, didn't you?*** The implication being that the pain of rejection, and the fear of further rejection, was so great that Jane retreated into herself. The impact on Jane of the rejection by the post-natal group is long-lasting. As she says: ***and it really sort of it sticks with me now cos I see this parent every day at school***. Here, Jane's description constructs the emotional affect she experiences daily as she goes about her ordinary maternal duties. Her account works to demonstrate how the normative mother/child activity of picking up her child from school is disturbed by the behaviour of these other mothers.

Accounts of rejection and ostracism feature routinely within the data collected for this study and support findings in the existing literature (see Chapter 3). Similar, but more dramatic, accounts of how mothers experience being ostracised by other parents are offered by Ingrid and Paula in the following extract.

Constructing a lack of moral integrity in the perpetrators

Extract 13, Ingrid, John, Paula

Ingrid: *yeah, they had a petition at [school] this is through what I found out through my friend they had a petition behind our back to get him out of school the parents the whole school ganged up together (unclear) apart from the few friends we did have*

John: *[big sigh]*

Alison: *that's terrible*

Paula: *that's quite common*

Ingrid: *to sign this piece of paper to you know to get him out and nobody and parents came out every single day and I couldn't go to school ground without my friend literally holding my arm I was terrified every single day some parent would come up to me and say 'your child did this, that, that to my child what you going to do about it?' and I said 'I'm sorry I can't' do anything', I said 'I apologise I can't do anything else' and I said 'he has issues we are dealing with it that's all I can say and if it's not good enough' and they were always when you took him to school (to J) they never said anything [everytime they always said something to me]*

John: *[yeah right well it was like there] was this guy no word of a lie he must have been six foot six and I found out afterwards that he was actually a policeman right? Now all the times I'd taken him to school and everything else not a word Irene takes him he squared up to you didn't he? Pinned you (?)*

Ingrid: *yeah in the middle of the school ground everybody flocking around looking down on me*

John: *shouting shouting his head off*

Ingrid: *just saying 'that's disgusting your the way your son behaves he did this to my daughter and there was just all these rumours (unclear) these five people [...]*

Paula: *(unclear) when M was in mainstream very similar to you to start with I used to get angry parents constantly but towards the end before he got the statement and moved school uhm they'd just all stand there and I'd be completely on my own and everybody would be saying 'that kid's just a little git' and' he does this' and you'd hear all the stories of what he'd done throughout the day but to each other loud enough [for]*

John: *[oh yeah]*

Paula: *you to hear but they weren't brave enough to come up and say [anything] they did that at*

Ingrid: *[no]*

Paula: *the beginning but when I sort of said 'well actually I'm not going to do anything because you're not behaving any better than he is uhm*

Group: *(laughter)*

Paula: *they sort of they weren't going to get anywhere with that so they then they started this sort of and it was sort of like a campaign to get 'we don't want that child in our class and better make sure he's moved'*

Clearly, this extract makes relevant victim/perpetrator subject positions. Ingrid and Paul construct the 'other' parents in the school playground as unreasonable, and their behaviour as bullying. Crucially, this account works to separate the speakers' (Ingrid and Paula) moral position from that of the other parents.

The use of the phrase 'the parents', and the repeated use of the generalising pronoun 'they' constructs a homogenous group identity (Benwell, 2012) from which Ingrid and Paula are excluded: ***the parents, the whole school ganged up.*** This works to formulate a 'them and us' construct, which, in this instance,

represents Ingrid and Paula as victims (the 'us') of the other parents' (the 'them') prejudice and bullying.

Although the word 'bully' is not used, it is inferred through Ingrid and Paula's accounts of the behaviour of the other parents. As Sacks (1995) and Stokoe (2009, 2003) suggest, categories referring to people carry with them a set of category bound activities. The activities described can all be recognisably attached to the category 'bully'. Ingrid and Paula's talk refers to petitions and campaigns being organised against them. Ingrid describes how parents 'ganged up' against her with ***everyone flocking round looking down on me***. The bully identity is further formulated through inferring the gendered subject positions of 'weaker', more vulnerable mother and the 'stronger' father. Ingrid addresses her partner directly when she says ***they were always... when you took him to school they never said anything. Every time they always said something to me***. Ingrid's comment is taken up by John, her partner, by making relevant the size of one of the fathers in the playground who was particularly vocal: ***he must have been six foot six [...] now all the times I'd taken him to school and everything else not a word Ingrid takes him he squared up to you didn't he?*** By making relevant size and gender, Ingrid and John invoke the category bound activity of a bully to pick on people 'not of their own size'.

The bullying behaviour is formulated as not just occurring on one occasion but as routine. As in Extract 11, Ingrid and Paula make use of the generalising pronoun 'they' to construct their experiences as regularly occurring: Ingrid states that ***they had a petition at school and*** later, Paula describes how ***they'd just all stand there***. Paula's contracted use of the word 'would' in the last quote, further establishes these events as routine, and typical of the actors described (Potter, 1996).

Extreme case formulations are also used to construct these events as regularly occurring. As Paula says ***I used to get angry parents constantly***. Their use of ECFs, not only formulates these instances of bullying as routine, but adds to the robustness of their accounts of marginalisation. The legitimacy of Ingrid and Paula's complaints against other parents is upheld through descriptions such as ***the whole school ganged up [...] and parents came out every single day [...] everytime, they always said something to me [...] they'd just all stand there.***

The use of ECFs constructs these events as unreasonable. Firstly, their frequency is formulated as incessant and, thus, unacceptable, and secondly, Ingrid's and Paula's marginalisation from the dominant group is attributed to all the parents, not just a few. It is a total marginalisation. The effectiveness of ECFs depends on an assumption of shared knowledge between the speaker and the listener. In this case, Ingrid and Paula assume a shared understanding that entering a school playground to pick up a child from school, should be an ordinary, mundane activity, free from scrutiny and condemnation. The excessive and extreme behaviour described in their accounts breach socially acceptable norms. The recognisability of the offenders' wrongdoings (Pomerantz, 1986:221) is clear to all.

These 'wrongdoings' are further evidenced through the use of reported speech. There are several incidents of reported speech in Extract 13, some of which are attributed to the other parents, some of which are representative of what Ingrid and Paula said. The use of reported speech attends to issues of the epistemological and action orientation of accounts. With regards to the former, reported speech works to corroborate the factuality and authenticity of accounts by making descriptions more vivid, dramatic and, seemingly, authentic (even if RS is understood to be emblematic of what was said, rather than a literal representation), and to make accounts less likely to be challenged (see Parker and O'Reilly, 2012:465). With regards to the latter, Ingrid and Paula use reported

speech to convey a version of events which portrays the morally ambiguous character of the parents making the statements. Buttny and William's study (2000) identified how reported speech was used in the accounts of black students of their experiences of receiving racist comments. Specifically, it was used to criticise and complain about 'out-group' members, by 'showing' their racist behaviour. In Extract 13, the audience are shown how other parents behaved through their reported speech: **'your child did this, that, that to my child, what are you going to do about it?' [...]'that's disgusting...your...the way your son behaves. He did this to my daughter...' [...]'that kid's just a little git'.**

As Stokoe and Edwards (2007:353) suggest, reporting insults where the speakers are the recipients of insults is 'to invite the listener to make inferences about the producer of the [...] language' The speech reported in these examples is quite challenging and insulting, and directed towards Ingrid and Paula's children. It contributes to the construction of these other parents as bullies, against which the speaker (and her child) is positioned as a victim. The 'bullying' nature of these parents is further invoked through the use of list extenders (in the example **your child did this, that, that**) and the use of 'would say' (in the example **some parent would come up to me and say...**), both of which establish a generic and routine form of reported speech (see Benwell, 2012; Stokoe and Edwards, 2007). These are not 'one-off' instances, but are repeated attacks, and, therefore, representative of the disposition of the perpetrators. The contrasting disposition of the speakers (Ingrid and Paula) is implied by the reported speech they attribute to themselves. Ingrid reports her response to one of the parents: **'I'm sorry, I can't do anything', I said. 'I apologise, I can't do anything else'**. The contrast between the insults of the 'other' parents and the repeated apologies of Ingrid serve to separate them, morally. Ingrid's behaviour is shown to be morally superior to those who judge her. The morally questionable behaviour of the other parents is explicitly invoked by

Paula who suggests that the comments other parents were making were loud enough for her to hear, but were not addressed to her directly as ***they weren't brave enough to come up and say ...*** As with Extract 12, the moral cowardice of the other parents is implied.

Reported speech not only 'reports' what others do, but also evaluates their actions (Buttny and Williams, 2000). One way in which this is done is to show how the speaker is affected by the reported actions/speech. In this extract Ingrid describes the effect of her ostracism by the other parents: ***I couldn't go to the school ground without my friend literally holding my arm I was terrified.*** In demonstrating the impact of these events on her, Ingrid invites the listener to experience what she did. According to Potter (1996), such narratives allow the listener to take on the position of the narrator and, thus, such accounts are inclined to be accepted as the 'correct' version.

The moral positioning of parents of children with ADHD is very much attended to in the talk of the parents in this study. Although fathers attend to issues of moral adequacy (see Chapter 7), the prejudice and scrutiny of others, and the moral positioning that this entails does seem to be a particular concern of mothers. The complexities of such positioning are revealed in the way mothers invoke social status when describing instances of perceived judgement or prejudice. In particular, mothers in this study (and fathers too) often align the judgement of others with an implied condescending, or in the words of one mother, 'snobby' attitude.

Lampooning the critics

Extract 14, Focus Group 2 (Gill, Mick, Rachel, Jane and Alan)

Gill: *yes we've had people say 'can you control your child because he's screaming on the aeroplane and I'm trying to concentrate your...'*

Mick: *we've had somebody say (mock 'posh' accent) 'why don't you speak to him?' and I've said 'we've been entertaining him for an hour now and we're exhausted do you want a go?' [...]*

Rachel: *it's very easy for people to judge isn't it?*

Jane: *I think it is [...] yeah and we've had a couple of bad ... we get a lot of parents I think well I see it more than you but I think are just quite snobby in their 'oh yes yes yes I know that exists but not in my back yard' (posh voice) they accept that it goes on but they don't want to know about it*

Alan: *or they don't want their children to be part of it*

Many of the participants in this study mimic stereotypical upper-middle class accents when reporting others' judgemental comments about their children. In Extract 14, Mick and Jane put on such voices. Mick reports another passenger's querying of his and Gill's parenting when travelling by plane: ***we've had somebody say (mock 'posh' accent) 'why don't you speak to him?'*** and later in the extract, Jane adopts a similar voice when reporting the ignorance of other parents in relation to ADHD ***'oh yes, yes, yes, I know that exists but not in my back yard'***. She actually identifies this understanding as an example of snobby behaviour ***we get a lot of parents...I think are just quite snobby.***

The use of paralinguistic or prosodic features, such as accents, in reported speech implicitly conveys the attitude and identity of the original speaker (see Benwell, 2012; Johansen, 2011; Buttny and Williams, 2000) as well as the stance of the current speaker towards them. The rhetorical effectiveness of such paralinguistic features is dependent on shared values and a shared assumption of what is being invoked. In this case, it is arguable that the shared assumption of a stereotypical

upper-middle class voice is that such a voice conveys an attitude of superiority and condescension. By deploying these voices, mothers (and fathers) manage to successfully represent these people as being judgemental and prejudiced. The assumed voices convey an unfavourable impression of the speakers through the questions and opinions they espouse. However, there is also a parodying effect in the use of such stereotypical accents and so the voices also do work to ironise or lampoon the attitudes of the original speaker, which, in turn, works to undermine their criticism (by mocking it) and also to distance the current speaker from the claims being made.

In mimicking upper middle-class accents, it is arguable that mothers are making relevant social status as a concern within the local interaction. The following three extracts contain examples of such occasions.

Extract 15, Focus Group 1 (Ingrid)

Ingrid: *exactly everybody's looking at you and it makes you feel you know [...] it was the talk of the village*

Alison: *was it?*

John: *oh yeah*

Ingrid: *it was quite small a small place where we lived you know it was very up ...they were very snotty people [...]we were very hated*

Extract 16, Focus Group 2 (Jane and Gill)

Jane: *medication's another thing that I've been bitten badly by talking to someone about it and and obviously scared them to death and they thought 'oh my God I don't want this boy coming to tea'*

Gill: *really?*

Jane: *I think I I you know the area where we live in [...] H...(name of town)*

Extract 17, Interview (Caroline)

Caroline: *yes and the children my child in a state school was completely isolated and in fact one parent even said uhm in fact he had a best friend he was very close to him [...] and I remember the day that child er said ...my child came home and told me that this boy wasn't allowed to play with him anymore and when I ...and then I found out that what the mum said was that she thought that her child could catch what he had so ...and that was his last friend because everybody else ...middle class area you know not good enough you know he wasn't performing academically well that's not a good start in an area like this but you know the behaviour wasn't there and yes I was shunned in the playground*

All three extracts refer to the home town or village in which the family are (or were) located and Ingrid, Jane and Caroline all infer that there was a lack of acceptance of their child (and family) because of the middle-class values held by local residents.

It is particularly interesting that despite invoking social status, two of these mothers were from households with a high socio-economic status. By invoking social status in these maternal accounts of judgement and scrutiny, mothers would seem to be making relevant wider social discourses which implicate 'normal' family life with morality and social class. Current literature (Barnes and Power, 2012; Gillies, 2005) suggests that dominant notions of 'good' parenting are aligned with middle-class parenting practices, while 'deficit' parenting is typically attributed to working class parenting practices. As discussed in Chapter 3, 'good' parents produce 'good' children, and 'bad' parents produce 'bad' children. 'Troublesome' children,

such as children with ADHD, are, therefore, implicated with 'bad' parenting practices. The moral judgement of other parents is, in these instances, constructed as emanating from their middle-class social status. Resonating with Rose's (1999) account of the scrutiny of childhood and the location of the deviant child within the moral environment of the home, 'normal' (middle-class) family life would seem to be the means by which these mothers feel judged, or, indeed, judge themselves. These accounts suggest these mothers (and their families) are positioned as morally deficient and this is imputed to be a consequence of other people's middle-class values. However, such positioning is resisted by these mothers by inferring that these middle-class values are the result of a misplaced, even morally dubious, condescension or, as Ingrid suggests, 'snottiness'.

The undermining of these judgemental 'others' is achieved by appealing to shared understandings of the category 'middle-class', and, in particular, of the category bound activities and attitudes which can be inferred from belonging to such a category (Stokoe, 2009, 2003; Sacks, 1995; Wooffitt, 1992). Significantly, all three examples appeal to this common-sense knowledge by deploying the generalisable 'you know'. Ingrid describes the place where her family lived as ***you know it was very up ...they were very snotty***. Jane offers an explanation for why some parents might not want her son to come for tea: ***I think I I you know the area where we live in [...] H...(town name)*** and, similarly, Caroline's son's lack of (local) friends is partially, at least, attributed to the middle-class attitudes of the area in which he lives ***that was his last friend because everybody else ... middle class area you know not good enough you know he wasn't performing academically***. The use of 'you know' works to create affiliation between speaker and audience (Clarke, Kitzinger and Potter, 2004) and, thus, appeals to (or even constructs) a shared assumption of what is being inferred. In this case, the inference is that judgment by others is a consequence of middle-

class condescension, snobbishness and ignorance. It is interesting that in these examples, participants undermine the implicit normative understandings of competent middle-class parenting by positioning such parents as lacking knowledge. Specifically, these parents lack the knowledge acquired through first-hand experience that they (the participants) have. This works to reverse the commonplace (and often class-based) binarisms of knowledge/ignorance, and, thus, responsibility and blame.

6.5 Summary

The analysis provided supports existing literature that suggests that mothers of children with ADHD are objects of scrutiny and objects of blame (Blum, 2007; Singh, 2004; Malacrida, 2001). The chapter has examined how mothers orient to the subject position of blameworthy mother, and how they, as Malacrida (2001:141) states, take up 'a wide range of discursive practices in attempts to position themselves and their families as worthy, deserving and knowledgeable.' The biological repertoire is drawn upon in mothers' accounts of relief at diagnosis and through their descriptions of their children's abnormality and this works to (partially) absolve them of blame for their child's behaviour. Similarly, mothers work to resist the blameworthy mother position with regard to medication. Mothers manage accountability for medicating their children through accounts of agency (and lack of agency). Finally, mothers resist blame by constructing victim and perpetrator identities, constructing themselves as (morally superior) victims, and others (usually other parents) as (morally inferior) perpetrators of intolerance, bullying and misplaced judgement.

As suggested at the beginning of the chapter, mothers are positioned within a blameworthy/valorised mother binary (Blum, 2007; Singh, 2004). The next chapter focuses on how mothers construct themselves as good, valorised mothers through

accounts that work up abnormality and, conversely, through their attempts to normalise their experiences.

Chapter 7 The Valorised mother

7.1 Constructing abnormality

Chapter 6 explored how mothers' constructions of victim and perpetrator identities perform moral work, with the victim as a pained and righteous 'innocent' (see Jansen, 2000) and the perpetrator as unfeeling and unjust. This chapter examines how the construction of victim identities, in particular, sons as victims, can also be used to provide a context for mothers' defence of their children and resistance to professional authority. The stigmatised and victimised ADHD boy is one already identified in the literature (Horton-Salway, 2012; Lloyd and Norris, 1999) and as Horton-Salway (2012:9) suggests, is regularly coupled with 'a valorised representation of the mother'. Mothers' constructions of their sons as victims, creates the possibility for them to occupy the subject position of the valorised mother and one way that they accomplish this is through constructions of themselves as 'abnormally' protective, vigilant and pro-active mothers, prepared to do battle with and on behalf of their children.

7.2 The battle metaphor

In both of the following extracts, two such mothers invoke battle as a metaphor for their dealings with professionals.

Accounts of battle

Extract 1, Paula

Paula: *(laughs) I do it's never plain sailing you know when you think you've conquered one thing there's always something else there's always another challenge*

Alison: *so it's hard to plan*

Paula: *yeah and the support you have to fight for, like for his statement and stuff, the fights I've had with that and I'm still fighting now about... because the school*

he's in now won't give him transport so I'm fighting constantly with them to prove that actually that is the only school that can meet his needs and you should be giving him transport you know why should I have to drive him to school everyday? It's 56 miles there and a day I do...

Alison: *oh my goodness*

Paula: *14 miles there and 14 miles back and I do that twice a day and it works out at 56 miles a day that I travel and when you've got chronic fatigue it's hard work to drive*

Alison: *you have chronic fatigue? Oh good God how do you manage?*

Paula: *I have to I don't have any choice (laughs)*

In Extract 1, Paula deploys 'fighting talk' to describe her past attempts to obtain a statement, and her current attempts to gain transport provision for her son. She uses the word 'fight' (or forms of it) four times and also uses the terms conquer and challenge: ***you think you've conquered one thing there's always something else there's always another challenge.*** The use of 'fighting talk' by mothers to describe their dealings with professionals' echoes findings in existing literature (see, for example, Norris and Lloyd, 2000). As with Paula's example above, fighting talk is deployed in relation to mothers' take up of a pro-active role when demanding access to health and educational resources for their children (for example, Todd and Jones, 2003). As Blum (2007) suggests, accounts of the intensified action taken by mothers on behalf of their children contribute to the project of 'concerted cultivation' whereby such accounts are offered as demonstrations of mothers 'doing' good mothering.

The use of 'fighting talk' introduces a moral dimension to Paula's description; it is not just a case of requesting access to resources and the request being denied or accepted. Invoking battle as a metaphor suggests there is much more at stake

than bureaucratic decision making. 'Fighting talk' positively valorises the mother by constructing a binary opposition; the mother is constructed as the child's lone supporter and is positioned vis-à-vis the unsympathetic professionals, negatively working against the child's interests. Paula in 'taking up arms' for her son is demonstrating her moral responsibility for her son, and she can, therefore, claim a 'positive moral identity' (Ribbens McCarthy *et al.*, 2000) for herself. As highlighted by Singh (2004), she is doing her job as a good mother to solve her son's problems. This representation of Paula as a morally responsible and dedicated mother is further strengthened by her admission that she suffers from chronic fatigue syndrome and that, despite this, she travels 56 miles every day to take her son to school. When asked by the interviewer how she manages this, Paula's reply is ***I have to I don't have any choice (laughs)***. By stating an absence of choice, Paula makes relevant the moral imperative prevalent in repertoires of good mothering, that maternal love is such that 'good' mothers will do whatever is necessary for their child even if it disadvantages the mother.

Paula punctuates her statement with a laugh. As Edwards (2005:13) argues, laughter is a device used to manage the subjective side of complaints and, in particular, it 'can signal that a complainable item, even when serious, is not something that the complainer is disposed to moan about, indulge in or make heavy weather of'. Paula's laugh thus works to minimise any possible understanding that she is complaining about her own situation. This resonates with Todd and Jones' (2003) findings that mothers avoid talking about their own needs as this could make them seem selfish. Talking about their own needs potentially undermines mothers' identities as their 'children's champions' (Todd and Jones, 2003:239), and risks the 'good' mother position. Paula's needs are, therefore, dismissed as of no consequence in relation to the more serious business of advocating for her son.

Invoking the language of battle, inevitably constructs a 'them and us' binarism, in which one side is represented as 'good' and one side as 'bad'. One way this is achieved is through David and Goliath (Jansen, 2000) type accounts, which position the child (and his family) as the 'victim' (David), and professional authorities as the aggressor (Goliath). By representing their child as victim, or underdog, mothers' resistance is not only morally sanctioned but becomes a moral requirement. Extract 2 provides further exemplification of this.

David and Goliath stories

Extract 2, Caroline

Caroline: *[...] and in fact what happened was he still didn't get the ADHD diagnosis what happened was he became uhm uhm er a great concern. The school couldn't cope in the end ...in the end the school admitted that they couldn't cope he'd stopped talking in school and become a selective mute uhm which was a great concern. We realised that psychologically he was in a very very bad place uhm [...] and the teachers were just shouting at him and uhm he'd just stopped responding so in the end we withdrew him from school uhm and we got him out it was the only option he couldn't go...and that took from up...this battleground really went on up until he was about to transition from year 2 up into the junior school and at that point it wasn't going to be a possibility for him to transition up [...] he was still ...I mean he didn't improve academically until probably this last year*

Alison: *ok how old is he now?*

Caroline: *he's just turned 13 [...] a year ago I would say he was still at a six year old level for his learning [...] he was very...and he's a bright lad [...] his IQ is at least average uhm eventually he ended up getting diagnosed as autistic spectrum*

disordered and he was then uhm he had to go to a specialist provision and we went to an out of county because there wasn't anything at that point in H (mentions county) and he was fully statemented at that point which was a battleground in itself [...] the statementing process was absolutely horrendous because we were not supported in that [...] and every possible uhm barrier was put in the way of trying to get him statemented but we fought through that with an awful lot of money and legal help [...] and so eventually we did get a statement after a long and arduous and horrible battle [...] and uhm we and he was actually at that time that we went he went into an out of county uhm part boarding uhm which worked really well for the first eighteen months but uhm I mean ...on reflection what was happening is that the Asperger's side of things was being handled fine [...] but the ADHD and the dyslexia were not [...] and that's where the difficulty was lying that the impulsivity wasn't understood [...] in the end that placement broke down completely so then he was...at that point he went to another ASD school but of course it was deemed that the behaviour... they couldn't cope with him because of his behaviour so he went to another ASD school that was more uhm s... for more sort of not severe children but for more severe behaviour [...] and again it worked ok at first but then as soon as they started to pile on the pressure after the first year they started to put the pressure on academically because he was quite again quite a damaged boy uhm [...] and they blocked it things just deteriorated I tried to flag up ... I could see that we wasn't coping he's a statemented child he was in a specialist school he was part boarding and I could see recognise the signs that he was in a desperate state and he wasn't coping but I wasn't being listened to again uhm and they again said it was that he needed discipline he needed to be brought

into line [...] and they just started to increase discipline and boundaries which is not what he needed and that crashed and burned completely when he started self-harming and tried to cut his wrists [...] he's been very very... well, how much more damaged can you get than you sit in a corner and you try and cut yourself and cut your wrists and then ring mum? ring me, school didn't even realise and he rang me and said 'mum I really want to die' at which point I just got in the car and drove down there put him in the car and drove off and said 'he's never ever going back there' [...] and the reason we survived that is that we are not prepared to take it lying down we threw our solicitors at it we just brought in solicitors we brought in experts and expert reports and we had the children diagnosed ourselves we've paid for all of this ourselves until we got the statement through

As with Paula in the previous extract, Caroline invokes the language of battle throughout this extract, using terms such as **battleground** (twice), **battle**, **fought** and describing the whole experience as **horrendous**. Her account suggests a life or death situation which was ultimately won through her (and her family's) determination to fight for a better understanding of her son by the education authorities: **and the reason we survived that is that we are not prepared to take it lying down.**

The life and death situation invoked by Caroline's description of struggle and survival is given further poignancy by her account of her son's difficulties, his attempts at self-harm and his expressed wish to die: **he was quite again quite a damaged boy uhm [...] he started self-harming and tried to cut his wrists.**

Throughout this extended extract, Caroline's son is depicted as the victim of poor and inadequate decision making by the educational authorities. Unable to defend

himself, Caroline takes up the advocacy role on his behalf. Her account positions the family (we) against various educational bodies (they) as they 'fight' over the best course of action for her son. As Horton-Salway (2012:9) suggests, boys with ADHD are often represented as the victims of injustice perpetrated by 'callous and uncaring' schools, unconcerned about the welfare of their students. This, in turn, makes available opportunities for mothers to take up the position of valourised mother as they 'take on' the 'Goliath' authorities in defence of their victimised children. The uncaring, indifferent attitude of the education authorities is juxtaposed with the caring, vigilant attitude of Caroline. In Caroline's account we learn that the **teachers were just shouting at him** and later, **they started to pile on the pressure**. Their academically driven expectations of behaviour are contrasted with Caroline's maternal intuition that: **I could see that he wasn't coping** and later, **and I could see, recognise the signs that he was in a desperate state and he wasn't coping but I wasn't being listened to again**. Throughout most of this extract Caroline deploys 'we' in her accounts of battle, presumably to denote both parents' involvement in taking on the authorities. The use of 'we' can be seen to provide credibility to Caroline's account. It suggests a unified front and, thus, works to undermine any doubts that Caroline is a loose cannon, overreacting to the situation. It also suggests a 'them and us' story, in which the 'we' of the family is constructed as a strong, cohesive unit, having to defend itself against the powerful, but faceless institutional 'they'. However, the footing of this account shifts with the introduction of the pronoun 'I' in Caroline's account of her noticing her son's pain and distress. This makes relevant the notion of maternal vigilance; it is only she that notices. In this extract, Caroline's harrowing description of her son's distress and the school's indifference to it, works to position her as vigilant and 'in tune' with his suffering, as any 'good' mother would be. Studies by Todd and Jones (2003) and Baruch (1981) suggest

that mothers provide emotional detail in their accounts of challenging encounters with medical professionals as a way of highlighting the 'lack of emotion' shown by professionals. As Todd and Jones (2003:232) say, emotional accounts of mothers' behaviour appeal to 'mothers' essential humanity and to the coldness and separateness of professionals'.

The somewhat 'essentialist' mother role is made explicitly relevant in Caroline's subsequent appeal to an assumed general consensus that in times of desperation you ring 'mum': ***how much more damaged can you get than you sit in a corner and you try and cut yourself and cut your wrists and then ring mum? ring me, school didn't even realise and he rang me.*** Caroline's account represents her not only as an advocate for her son's rights, but also as his 'saviour'. Despite being at school when he cuts his wrists, it is his mother he rings (not the 'we' of the family), and it is she who comes to his rescue; the school do not even notice. As Caroline reports: ***I just got in the car and drove down there put him in the car and drove off.*** The 'just' here works to establish the simplicity of this action, as a 'good' mother, this was the only course of action available to Caroline; the action needs no further explanation. Caroline's harrowing description of her son's distress, and her account of their subsequent struggle and survival resonates with Singh's (2004:1198) findings that 'mothers' desperation to save their sons must be understood as part of an effort to preserve part of their deepest identity as women and mothers'.

The battle metaphor is also deployed in mothers' harrowing accounts of their children's extreme behaviour. In these accounts the 'battle' is between mothers and sons. This is an interesting shift as the actors are repositioned so the son as victim becomes the son as perpetrator, even enemy. Clearly, this also demands a

shift in the mothers' own positioning (see Parker and O'Reilly, 2012). The following section looks at how mothers manage this shift in alignment.

Accounts of battle are used to work up abnormality, both in respect of the behaviour of the child, and also in respect of the parenting strategies required. It is through these accounts of 'battle' that mothers demonstrate their skill and expertise in managing their children and, crucially, their ability to cope.

In Extract 3, Paula provides a typical example of her battle with her son.

7.3 Abnormal parenting

Constructing abnormal mother son relationships

Extract 3, Paula

Paula: *and actually it's not... like I say to my son 'I don't like some of the things that you do but I understand why you do them and it's not your fault that you can't control yourself but what we need to do is think of what you could do instead of doing that' you know 'what would be a better solution to feeling like that than doing that like?' When he was little he used to attack me physically [...] but now he doesn't hit me at all [...] when he was younger and I was a bit naive about his condition I used to think he hated me and some of the names he calls me even now it does hurt I won't ever say it doesn't hurt but you have to realise you have to make yourself and talk yourself into the fact that actually he's angry and he's saying them words with no feeling he's not saying them to hurt me well he probably is but not in that way he's angry and he needs you to know he's angry and that's how I deal with it now but I didn't when he was younger I mean I did spend a lot of time in tears you know mismanaged him quite badly at the beginning cos I didn't know. [...] I didn't have a clue I just had this child who was*

really uncontrollable and quite violent and I didn't know what to do and so I did end up in quite a lot of physical uhm things with him and uhm he hurt me numerous times you know he tried to push me down the stairs he threw scissors at me threw knives at me and I ended up with a broken nose where he headbutted me in the face uhm black eyes you know he was very very violent

Alison: *it's not what you sign up for is it?*

Paula: *no and I would you know trying to restrain him was what I thought I needed to do and actually that just ended up getting me more hurt uhm and it wasn't until I read a bit about ADHD and I thought 'I know I'm going to let him hit but he's not hitting me anymore we've got to find something else he can hit' and that's when I (unclear) the punchbag and I did that with him [...] he doesn't do it he very very rarely attacks anybody he'll throw things and he'll still wreck things in the house if you're not able to intervene quick enough uhm but he wouldn't physically hurt anybody now*

Alison: *no so he's learned that from you then?*

In this extract, Paula provides a before and after account that pivots around her interventions as a mother with respect to her son's behaviour. His previously extreme and violent behaviour is contrasted with his behaviour now ***when he was little he used to attack me physically, [...] but now he doesn't hit me at all*** and Paula accounts for the change in his behaviour as being the result of her developing skills as a mother of a child with abnormal needs and her consequent ability to teach him certain strategies.

As discussed in Chapter 5, parents construct pathology in their children as a way of reifying the biological repertoire, which in turn, works to absolve them from blame or responsibility for their child's behaviour. Constructing abnormality is also

used by parents as a way of demonstrating the extreme stress and difficulty they experience in parenting their children. Clearly, deploying accounts of stress and difficulty in parenting is a risky position to take up. If parents provide accounts of not being able to manage their child, then they risk being understood as ineffective parents, and this works to justify their possible positioning as bad parents, and risks implicating them as causal factors in their child's condition. However, without accounts of abnormality, then their child's behaviour risks being understood as normally naughty and the parents risk being understood as overreacting, and possibly making false claims about their child's condition as a way of excusing their child's behaviour. This again, positions them as bad parents. One way which parents manage this double bind is by making relevant the subject position of the abnormal child and, subsequently, constructing accounts of successful parental management of this abnormal behaviour. Further to existing literature (Bull and Whelan, 2006; Litt, 2004; Segal, 2001), accounts of coping with their children's behaviour are particularly apparent in mothers' accounts and these accounts can be understood as mothers providing legitimacy for claiming the subject position of the good mother.

As Potter (1996) suggests, abnormality is typically, indexically constructed in discourse through the use of contrast structures (see Smith's, 1978 study of mental illness). For example, in Paula's description, her son's 'littleness' and child status is contrasted with detailed accounts of his physical violence: ***when he was little he used to attack me physically*** and ***I had this child who was quite uncontrollable and quite violent***. Paula's invocation of the 'child' draws on the shared assumption that children are vulnerable and innocent; they are not the perpetrators of harm as her son was. The previous behaviour of Paula's son is further worked up as abnormal through the use of script formulations (Edwards, 1994; Sacks, 1995). Through the use of adverbial phrases of frequency (as in ***he***

hurt me numerous times) and grammatical devices such as ‘used to’ (***he used to attack me physically***), his behaviour is formulated as typical and routine for him. However, in singling out his behaviour as worthy of description and account, then it is simultaneously contrasted with an implied norm of expectable childhood behaviour. As Edwards (1994) argues, shared background knowledge of what constitutes a normative base is assumed through the deployment of script formulations. In this case, Paula’s son’s behaviour can be understood as breaching normal childhood practices and can, therefore, be understood to be pathological. However, in making relevant the subject position of her son as a child (young person), he becomes less accountable for his behaviour.

This lack of accountability is further formulated through descriptions of his behaviour being dispositional and to an extent involuntary; it is behaviour that he has no real control over. As she reports she says to him, ***‘It’s not your fault that you can’t control yourself’*** and later, ***you have to realise you have to make yourself and talk yourself into the fact that actually he’s angry and he’s saying them words with no feeling he’s not saying them to hurt me.*** By constructing his behaviour as dispositional, Paula further strengthens understandings of it as being biologically determined. However, it also does some work in constructing her son as not morally accountable for his behaviour and so not wilfully hurtful or violent towards her. He is not acting intentionally, he cannot help his responses. He is constructed as a different type of ‘enemy’ from the parents at the school gates, or the education authorities. Unlike her son, they are formulated as being responsible for their actions. In constructing her son as less culpable for his actions towards her, then she correspondingly becomes less of a victim (see Holt, 2011). In resisting being positioned as a victim vis-a-vis her son, she is able to (discursively, at least) assert her ‘rightful’ parental authority over him. Accounting for his lack of culpability also makes available the ‘understanding

and forgiving' mother identity, which is linked with essentialist notions of what it is to be a good mother.

However, Paula's account establishes that her current understanding of her son not being culpable for his actions is a learned one. As she admits ***I used to think he hated me [...] that's how I deal with it now but I didn't when he was younger I mean I did spend a lot of time in tears you know mismanaged him quite badly at the beginning cos I didn't know [...] I didn't have a clue.*** These 'before and after' accounts of changed understanding resonate with the 'at first I thought, but then I realised...' discursive device, which is used to report unusual or exceptional experiences whilst simultaneously presenting the speaker as a reliable and ordinary witness to events (see Sacks, 1995; Pollner, 1974; Wooffitt 1992). In this case, the 'before and after accounts' work to present Paula as having the same expectations and assumptions that any 'normal' mother would have of her child. As Widdicombe and Wooffitt (1995) argue, doing 'being ordinary' is a way of countering other people's inferences or assumptions about her identity or conduct. She is not responsible for the abnormality of her current situation, she was as surprised and shocked as anyone would be by her experiences, and has had to learn to adapt ('doing being ordinary' will be returned to later in the chapter).

Coping with abnormality

The notion of 'learned mothering' is one that features within the existing literature relating to mothers of ADHD children (Taylor *et al.* 2006; Litt, 2004; Segal, 2001). As discussed in Chapter 3, mothers are keen to demonstrate their acquired strategies and skills to cope with their children's behaviour and this is certainly true of the mothers within this study too. As also stated in Chapter 3, from a discursive perspective, caution should be taken in accepting face value accounts of maternal coping strategies. More significantly, talk of coping should be examined for its

discursive accomplishment (see Wilkinson and Kitzinger, 2000). In this instance, coping with and managing disruptive children is a moral requirement of a 'good' mother. Paula demonstrates her 'good mother' strategies in various ways. As with many of the mothers in the study, she uses direct speech to report her own interactions with her child and to provide exemplification of some of her parenting strategies: *like I say to my son 'I don't like some of the things that you do but I understand why you do them and it's not your fault that you can't control yourself but what we need to do is think of what you could do instead of doing that'*. Reported speech invites the audience to 'witness' the events rather than be told what happened (Buttny and Williams, 2000); in this way, reported speech can be seen as a device which obscures a speaker's interpretation and construction of events, even if the direct speech originated with the current speaker. Reported speech here is presented as a neutral and factual account of what actually happened, and resonates, in this particular use, with features of empiricist discourse which aim to construct 'out-thereeness'; that is, impersonal and neutral accounts of events as having a life of their own (Potter, 1996; Woolgar, 1988). By shifting to direct speech, Paula is *demonstrating* her 'good' mothering skills, whilst maintaining a 'reporter's' neutrality in providing an account of it. We are not *told* that she negotiates with her son sensitively and sensibly, we are *shown* it. She thus counters possible interpretations that she is mistaken in her account of her skills at managing her child. The use of reported speech to demonstrate maternal management of their children is used regularly by the mothers in this study.

The construction of expertise is also a concern for mothers when demonstrating their skills at coping with challenging behaviour from their children. As with Paula in Extract 18, many mothers describe how they 'skill up' by reading about the condition or seeking expert opinion: *it wasn't until I read a bit about ADHD and I*

thought ‘I know I’m going to let him hit but he’s not hitting me anymore we’ve got to find something’. This resonates with existing literature which suggests parents account for the successful management of their children in terms of the development of in-depth knowledge about their child and their child’s condition (Taylor *et al.*, 2006; Segal, 2001). The gaining of expert insight into how to manage her son is constructed by Paula to be an almost epiphanic moment. It is interesting that she shifts from using the ‘I’ pronoun, which she has used throughout this account, to using the ‘we’ pronoun. Again, this works to suggest a resistance to a possible victim identity; it certainly contrasts with the preceding ***he’s not hitting me anymore***. No longer is Paula positioned as the victim vis-à-vis her violent son; through the gaining of knowledge, the vulnerable ‘I’ (the potential victim) becomes the more powerful and united ‘we’. As highlighted by Parker and O’Reilly (2012:464), use of the pronoun ‘we’ works to distance parents from assuming sole responsibility for managing their children’s ‘problematic’ behaviour. Although it is not made clear who the ‘we’ refers to in Paula’s account, finding a successful way of dealing with her son, is now constructed as a shared responsibility.

This is echoed in mothers’ accounts which suggest a professional partnership between themselves and teachers or SENCO officers, as exemplified by the following extract, which comes from the interview with Gill and Mick.

Constructing the professional parent

Extract 4, Interview with Gill and Mick

Mick: *but but we prompt him we say ‘I control yourself control yourself’ (in a firm voice) and anyway ‘agh’ and he screams and shouts and we say ‘what is what will screaming and shouting get you?’ and he knows that it gets him nothing*

and he's sort of 'nothing' and so he ...so au...au...audio cues like that help him to just wsssh uhm

Gill: *that's all we need to say now 'screaming and shouting gets you...?' and he goes 'nothing' (big sigh) and that's it [...] and it works and it works for the school they say that he responds very well to the same cues so whatever phrases or things we use we'll tell the school*

Alison: *[you'll tell the school?]*

Gill: *[and they'll use] yeah and if they find things that work they'll say 'oh by the way we've learned that if we say 'ooh remember you'll go to year one if this behaviour continues'' so then so then ugh if at home he's doing something or ...we'll say 'remember if you don't do your...you know if you don't or you behave like that at school you'll go to year one' and he knows that [...] he he's able to think a lot more now about consequences and I never thought that would happen really never thought that would happen*

Alison: *that sounds as though you're working really quite closely with the school is that right? [...]*

Gill: *I seem to be uhm a project manager and I think you find that a lot with the parents it's...and I felt do you know what he's my son so it's my job to liaise with school and do my own research and do ...find out from psychiatrists and I'm the one who pulls the information together for him*

As with Paula's account of parental coping strategies in Extract 3, this extract begins with Mick and Gill demonstrating through the use of reported speech how they 'manage' their son's behaviour. The success of these strategies is confirmed by the independent corroboration of the school: **they say he responds very well to the same cues**. Although not an example of direct reported speech, this use of

indirect reported speech, resonates with Wooffit's concept of active voicing (Wooffit, 1992), in which speakers establish objectivity about the claims they are making by providing a quote from an independent witness, which confirms the facticity of their account (in this case, that their parenting techniques are successful). Additionally, the use of the plural pronoun 'they' works to construct this opinion as held by a range of people, or teachers, rather than, say, just one teacher (see Potter, 1996), further strengthening Gill's claim that these strategies work.

In this account, Gill reveals that she lets the school know of any strategies that work at home, so they can be used by the school. However, this is a potentially risky representation. There is a delicate path to be negotiated between the positive subject position of the parent who is engaged with their child's schooling and the negative subject position of the parent who is too involved, or even interfering, in their child's school life. As outlined in Chapter 3, mothers who appear as confrontational or challenging can be considered to be less deserving of resources and support (Berman and Wilson, 2009), and, generally, do not invite sympathy or empathy. Perhaps as a way of countering being heard as an interfering, and troublesome, mother, Gill immediately follows her admission that she lets the school know of the strategies that work for her, with the information that she is equally open to receiving information from them: ***Alison: [you'll tell the school?]***

Gill: [and they'll use] yeah and if they find things that work they'll say 'oh by the way we've learned that if we say 'ooh remember you'll go to year one if this behaviour continues' In showing her willingness to accept 'tips' from the school, she represents herself as co-operative and open to receiving advice. However, despite this openness to suggestions from the school, Gill is far from passive and this quid pro quo exchange of information works to construct her and

the school as professional partners, exchanging mutually beneficial information about her son. The professionalism of Gill's role is further produced in her use of language which draws on professional, managerial discourse: ***project manager [...] my job to liaise [...] do my own research [...] I'm the one who pulls the information together for him.***

Many of the mothers draw upon professional language in their accounts of managing their children, and especially in their accounts of interacting with schools and medical experts. The use of such professional language again contributes to the construction of abnormal parenting experience: special children, require special parenting approaches. However, it contributes to an understanding of these mothers as being skilled, effective and expert in dealing with their children, and can be understood as another way of countering dominant understandings of them as ineffective and unskilled mothers. It also works to make relevant notions of maternal entitlement and authority potentially lost by mothers subject to so much judgement and scrutiny. Certainly, Gill's account clearly positions her as the one in charge of her son. In invoking her 'duty' to her son, she is indicating a privileged status in relation to him vis-à-vis the school, and in so doing establishes her own power entitlement to assume responsibility for him.

In Extract 5, Jane similarly constructs her expertise within an account of her and Alan's interactions with their son's school. Jane's expertise is constructed as originating from her experiential knowledge of her son, and, unlike Gill, she uses her entitlement to epistemological warrant to undermine the expertise of the teachers, an expertise which might have value when dealing with 'normal' children, but which does not work when dealing with 'abnormal' children such as Jane's son.

Constructing entitlement to epistemological warrant

Extract 5, Jane and Alan

Jane: he has a teacher at the moment who shouts a lot which he doesn't respond well to at all [...]

Alison: yes uhm how do you deal with that? Do you suggest that that's not very helpful to him to the teacher or is that difficult to do?

Jane: that's [on no (unclear)]

Alan: happily go in and tell them they're crap (laughs) [...]

Jane: I went in last week you know it's you know and [a lot of it's]

Alan: [and I told the] headteacher that he's useless can't run a school to save his life

Jane: it's just to do with communication and uhm i..i..i.. and you know

Alan: I think if we didn't have a statement it ...we wouldn't be on [...] but we...cos we've got a statement we go 'yeah look' I don't care about the 30 other kids in the class

Jane: we do have somebody here so you can differentiate [...] we do have a home school book please use it uhm [...] but I think because the school don't see the... I mean I would say most of the self esteem comes out of the anxiety I mean it's all [...] anxie... the whole the key to it all is anxiety every... I'd say every ...

Alan: there's an anxious moment which makes him... [go]

Jane: [yeah] and you won't know what that anxiety comes from because he's not able to explain it so he'll he could be talking about something completely different but the anxiety will be [...] rearing its head from something else [...] uhm changed the homework policy at school so it's not being done on line there's now a counting clock a clock counting backwards so he's ...

Alan: and all he's worried about is the clock

Jane: *yeah [...] and all the teachers are talking about is consolidating learning and I'm thinking 'you've missed the point completely'*

Alan: *yeah so I think a lot of education needs to go into the teachers to help them (pause) teach that sounds really bad but it's ...some of the newer teachers probably have some maybe that awareness of different [...] the teacher at the moment says 'ooh he fiddles a lot'*

Jane: *so that seems to be focusing on the couple of negative things rather than concentrating or recognising on [the things that are working] [...] yeah so that you know those sorts of things are ...make a difference to us at home as well where we're trying to manage what's going on and it gets very frustrating I think I was in there again with this homework because the aftermath of that was coming home being so anxious being so worried about getting it completed on time that he'd actually miss the instruction about what he needed to do [...] so it's just sort of saying to the school 'look we need to...' you know it might sound like a repetitive pattern of things going wrong and they don't seem to change [...] because that's the other issue if nothing ...all these problems that he has is that we end up doing much more at home with homework than with any other parent would and I mean just to try and get a child to sit down because in his mind 'school's school' 'home's [home] they're] separate [...] and then you're sort of saying to the school 'can you help us to ...with some strategies what works what gets him sitting down?' [...]*

Jane: *and I think that the current teacher is obviously moving the rest of the class along this independence route at a rate that's too quickly for him what too quick for him so I think she finds it very hard to understand that you know he's in her eyes I think he's quite mollycoddled you know for...as a lot of the kids are*

in the class and it's sort of like well that's your own personal view and that comes through which which it shouldn't and you just sort of think 'well actually it's no good you just keep batting this back into my court because he's supposed to be learning in your environment'

Alison: *mmm mmm*

Jane: *oh no don't get me started*

Alison: *(laughs)*

Jane: *but you know it's a and that's another jibe at your parenting [...] and you're thinking actually I've got enough in my remit [...] as a parent without having education on on the top*

Jane and Alan's co-constructed account is critical of teachers and their approaches to managing their son. It is interesting that, in this instance, the undermining of teachers' expertise is accomplished quite differently by the couple. Alan's critique of the teachers is quite blunt and even confrontational. He admits that he will ***happily go in and tell them they're crap (laughs)*** and he reveals that he ***I told the headteacher that he's useless can't run a school to save his life.*** This contrasts with Jane's more measured and tactful undermining of their expertise ***it's just to do with communication.*** Although we learn in this account that Jane has been in to speak to the teachers on several occasions: ***I was in there again with this homework***, her actions are constructed as reasoned, measured and professional. This resonates with previous literature which suggests mothers, at times, present themselves as compliant and deferential in potentially confrontational situations with experts to avoid being understood as difficult, troublesome, and even pathological (Berman and Wilson, 2009; Austin and Carpenter, 2008; Malacrida, 2001).

As with the previous extract, Jane occupies a professional mother subject position by drawing upon the language of work, in this case, pedagogy, and she uses this language to criticise the teachers' practice. For example, Jane comments that because her son has a statement, then there is a need to differentiate within the classroom: **so you can differentiate [...]** She also dismisses teachers' aims to consolidate learning as ill-conceived and misplaced: **all the teachers are talking about is consolidating learning and I'm thinking 'you've missed the point completely'**. Jane's entitlement to criticise the teaching practices affecting her son, is grounded partly in the, earlier learned, fact that she trained as a teacher, but also from the experiential knowledge warranted by her position as the mother of a child with ADHD (see Sacks 1995). This category entitlement differentiates her experiential knowledge of how best to deal with her child, from the pedagogic 'expertise' practised by the teachers, an expertise that she herself can draw upon in order to undermine it. Jane's experiential knowledge of her son is constructed as the 'superior' knowledge, and entitles Jane to make claims about strategies that do and do not work: **he has a teacher at the moment who shouts a lot which he doesn't respond well to at all [...]** It also entitles her to make claims about what lies at the heart of some of her son's behaviour ... **the whole the key to it all is anxiety.**

In this particular account, Jane and Alan suggest that inflexible school homework policies and the inflexible attitudes of teachers impact negatively on the behaviour of their son, both at school and at home. In criticising the inflexible disciplinary presence of the teachers, Jane risks being understood as averse to discipline and, thus, an ineffective and feeble parent, who lacks a disciplinary presence, a subject position made available through the psychosocial repertoire of ADHD. Jane, however, attends to this potential criticism of herself, by 'voicing' the potential criticism that the teachers (and the audience) may have of her: **I think she finds it**

very hard to understand that you know ...he's, in her eyes, I think, he's quite mollycoddled you know. In this instance, by 'voicing' the suggestion that she mollycoddles her son, Jane is identifying with her audience and showing that she is aware that this might be a common-sense understanding of the situation. As Billig (1996:269) argues, such remarks, which seek 'an accommodating common ground with the potentially critical audience' act as disclaimers, which deflect criticisms and, in fact, work to protect the identity and integrity of the speaker. Jane constructs an alignment with her audience (also through the use of ***you know***), which, in turn, makes it more difficult to hold an alternative view to the one presented by her.

The 'merging' of the professional and maternal is further implicated through Jane's closing remarks in this extract: ***and you're thinking 'actually I've got enough in my remit [...] as a parent without having education on on the top'***. The use of the word 'remit' suggests a professional context, perhaps in relation to a job specification. Jane also implies that her maternal duties currently include educating (as in teaching) her son. The 'teaching' of academic skills is a practice that several of the mothers in this study describe themselves as taking on, whether through official home education (Caroline) or through ad hoc after school sessions on phonology (Gill).

Experiential knowledge is also drawn upon in the accounts of these mothers to challenge 'normal' and/or 'taught' parenting strategies. As Rachel states in the following extract: ***normal rules of parenting don't apply.***

Normal rules of parenting don't apply

Extract 6, Rachel

Rachel: *it's very confrontational at times too and normal rules of parenting don't apply because they or he will always go to the next level*

Extract 7, Linda, Ingrid, Paula (focus group 1)

Linda: *yeah and you know and if a number of times 'well you know they need more boundaries' and you think 'God you've got no idea of the boundaries we've got' (lots of laughter)*

Ingrid: *(unclear) they can't do they can't do boundaries [...] they can't do... you know they all talk about 'ah you know put him on the naughty step' oh my God (lots of talk) [...] and you think it doesn't work and it's about how you doing it how you know no no no*

Paula: *it has to be implemented so differently with children with ADHD and you do have an element of having to work with them and not against them*

In Extract 7, the mothers in the first focus group collectively work up a joint construction of how their children require a different type of parenting. Typical parenting advice from unspecified 'others' is demonstrated using reported speech **'well you know they need more boundaries'** and **'you know put him on the naughty step'**. Reporting the words of advice works to demonstrate the mothers' familiarity with these often repeated 'good' parenting strategies, which in turn legitimises their rejection of them. The use of 'you know' within the reported speech invokes a shared cultural knowledge that such parental strategies are routine (Gray, 2008), a cultural knowledge that is shared by the current speakers. The reported words of advice are undermined by making it clear that such techniques are obvious and simplistic and, clearly, one of the first things tried by a 'good parent' (see Gray, 2008), and, crucially, by these parents. As Linda suggests, it is not a question of parents of ADHD children not having any

boundaries; it is that they have so many; she provides a response to the advice givers '**God you've got no idea of the boundaries we've got**' (*lots of laughter*).

The laughter which follows this statement indicates alignment with and confirmation of Linda's description of people's misguided parenting advice (see Jefferson, 1984). 'Normal' parenting rules do not apply for these mothers, their children's behaviour requires exceptional parenting that exceeds that of parents of 'normal' children. As Paula says ***it has to be implemented so differently with children with ADHD and you do have an element of having to work with them and not against them.***

Parenting strategies are frequently referred to by the parents in this study. Parents' accounts both demonstrate a familiarity with and a performance of 'good' parenting practice, and, at other times, also a rejection of such recommended practice. Talk about parenting strategies typically features in accounts of parenting classes that the parents were required, or advised, to attend. Although, presumably fathers were invited to join these parenting classes, and although fathers were very active in their critique of them, the fathers did not attend the classes as regularly as the mothers (if at all), and for this reason I have included this section on parenting strategies and parenting classes in this chapter on mothers (see Chapter 10 for a discussion of parenting practices in relation to mothers and fathers). Also, the topic of these parenting classes was a concern made relevant by all the mothers in this study (and by fathers on behalf of the mothers).

As Holt (2010) describes, in her study of parents subjected to Parenting Orders, parents are positioned within a double bind in relation to parenting classes. If parents fully engage with the classes, and adopt different parenting strategies to deal with their children, then, clearly, they were in need of 'training', and their

identity as 'deficient' parents was justified. However, if parents refuse to engage, then they risk further scrutiny and interference. As Holt (2010) argues, parents need to be seen to engage, while resisting the need to change. As with Holt's study, one of the ways in which the mothers in this study resist the need to change is by drawing on their own experiential knowledge of their children and claiming a 'lack of fit' between the practices put forward by the parenting experts and their own 'extraordinary' familial situations.

In Extract 8, Ingrid and John are talking about the parenting groups that Ingrid has attended. Although in this extract, resistance to the strategies offered by the parenting classes is co-constructed by John and Ingrid, I have chosen to analyse this extract within the chapter on mothers, for the reasons given above.

Extract 8, Ingrid and John

Ingrid: *oh yeah I've been to three parenting groups (laughs)*

John: *but ...so basically they're they're talking about their children 'well (tuts) well (tuts) he doesn't tidy up when I tell him to' [...]*

Ingrid: *oh my God I'd be so happy if I had that problem (laughs) yeah their issues were completely ...and you know I didn't say I didn't pick anything up because I did you know I I you know you can hear things and you think 'oh I can turn that into...' and you know [you can use your imagination] [...]*

John: *yeah there's always room for that of course everyone needs their [...] or whatever but the actual ...the principle of what we're talking about the ADHD uhm side of it is just there's nothing there there's nothing you know it's like 'hang on' as you said 'this isn't ...what your child doesn't clean up' (laughs with ridicule) 'what?'*

Alison: *so there weren't parenting groups for children with ADHD? they were just [...]*

Ingrid: *no they said ...I went to the Stratton Webster Stratton which they said was specifically for children with very bad ...you know [...] and I... you know they they'd all talk about the 1 2 3 you know timeout and stuff but they were focusing a lot on that and none of them things worked on L so most of the time I was sitting there going ...*

John: *sticker charts yeah done that done it done it done it done it*

Ingrid: *sticker charts [...] but they only worked for a short moment of time because he doesn't have the same you know...he's only [(unclear) in that] second*

John: *[yeah they'll work for a week] they'll work for a week maybe at most*

Ingrid: *yeah exactly and then it'll be something else*

Ingrid's admission at the beginning of the extract, that she has been to three parenting classes, is punctuated by her laughter: ***oh yeah I've been to three parenting groups (laughs)***. This marks the beginning of a complaint about the 'content' of these parenting classes. Her use of laughter indicates that she is 'troubles-resistive' and in a position to take the situation 'lightly' (Jefferson, 1984:367). As described earlier, this works to manage her identity as someone who is not prone to making complaints (see Edwards, 2005). Significantly, the laughter is not echoed by the listeners. As Jefferson (1984) suggests, laughter which is intended to indicate something humorous is, typically, responded to by a recipient display of affiliation, that is, by the listener joining in with the laughter. In this case, Ingrid's laughter is not responded to with laughter from either her husband or the interviewer. The serious response signals a recognition that Ingrid's account is not to be understood as humorous, but as an indication that she is constructing an account of 'troubles'. Similarly, Ingrid uses laughter to close the following statement: ***oh my God I'd be so happy if I had that problem (laughs)***. In setting up her account as one which is attending to 'trouble', then her statement

can be understood as ironic and inferred to mean that she would be happy to have the problem of her son not tidying up his room because her problems (in relation to her son) are so much worse. The strategies offered by the parenting groups are resisted as not being appropriate by Ingrid and John, and the implication is that this is because their son has different requirements: ***they'd all talk about the 1 2 3 you know timeout and stuff but they were focusing a lot on that and none of them things worked on L*** and later, ***sticker charts [...] but they only worked for a short moment of time because he doesn't have the same you know...***

As Holt (2010) suggests, resisting taught parenting strategies is risky business as parents, in order to display a positive moral identity, need to show a willingness to assume responsibility for their children (Holt, 2010; Ribbens McCarthy *et al.*, 2000). One culturally sanctioned way of displaying a positive moral identity is to show willingness to engage with parenting expertise. Although John communicates his and Ingrid's resistance to some of the methods taught through his exasperated dismissal of sticker charts, he does make it clear that they are (or have been) willing to engage with the strategies taught at the classes: ***sticker charts yeah done that done it done it done it done it***. The repeated use of 'done it' suggests that they have used them several times but, crucially, to no effect.

Ingrid mitigates her resistance to the taught strategies by conceding that she was able to learn something ***you know I didn't say I didn't pick anything up because I did, you know, I I ,you know, you can hear things and you think 'oh I can turn that into...' and you know, you can use your imagination.***

However, even within this concession, Ingrid is resisting the assumption that these parenting classes could offer her something entirely appropriate or practical. The strategies offered are only useful once she adapts them to the needs of her child.

The riskiness of challenging the worth of parenting classes is further suggested by the hesitations and unfinished sentences that pepper Ingrid's account. For example, towards the end of this extract, Ingrid does not finish her description of what she was thinking while present at the parenting class ***so most of the time I was sitting there going...*** Presumably, she intends to convey that she was 'sitting there going 'this is a waste of time', but, again, to say that explicitly would risk Ingrid being understood as not willingly engaging in the parenting classes, and thus not prepared to assume moral responsibility for her son. This in turn, invites possible rebuke of her parenting.

Hesitations also appear in Ingrid's account of her son's needs 'not fitting' with the needs of the rest of the group. Ingrid's son's difference from the other children (whose parents attend the parenting classes) is inferred rather than stated explicitly: ***yeah their issues were completely ...*** and later, ***they only worked for a short moment of time because he doesn't have the same you know...***

Ingrid's son's difference is worked up through hesitant and vague descriptions. Vagueness has a rhetorical function in that it can suggest a broad categorisation of a phenomenon without the speaker having to account for specific details (see Potter, 1996). The fuzziness of Ingrid's descriptions of her son manage to formulate his identity as one which is different from the other children targeted by these classes, but without specifying what either his or the other children's 'identities' are. The construction of difference and abnormality is complex. As we have seen, biological abnormality is frequently worked up by parents in this study in their attempts to resist blame for their children's behaviour. Abnormality is, typically, indexically constructed in relation to normality. However, parenting classes are usually targeted at parents of children with behavioural problems (whether or not they have a medical diagnosis or not). These children do not, therefore, represent a 'normal' yardstick against which Ingrid's son can be

positioned as abnormal. The behaviour of all these children (and by association parents) is considered 'abnormal' in some way, hence their being directed to parenting classes. In describing the failure of the classes to promote any changes in her child and her management of him, Ingrid risks being challenged as to why, if the parenting classes work for some 'different' children, they do not work for her son. However, she averts this, by formulating her son's difference in vague terms, which she therefore does not have to account for.

Ingrid's hesitancy in the above extract is, perhaps, indicative of the tension that exists around making claims of abnormality and normality and, in particular, of what is at stake for mothers' identities in making such claims. As stated in Chapter 5, constructions of abnormality make relevant very different subject positions for mothers of children with ADHD than do constructions of normality. Constructions of abnormality can work to inoculate mothers, to a certain extent, from mother blame, and can also legitimise a valorised mother subject-position. The abnormal, extreme, and often very distressing, nature of their children's behaviour provides opportunities for mothers to 'go into battle' on behalf of their children and families. It also provides opportunities for mothers to formulate and justify valorised accounts of their own learned mothering, their developing skill at managing and coping with their children.

However, constructing abnormality also legitimises scrutiny and professional interference and strengthens parents' sense of having a 'spoiled identity' (see Holt, 2010; Goffman, 1990). Certainly, the parents within this study describe themselves as objects of scrutiny and judgement and nearly all accounts are constructed to resist claims that they are bad parents, perhaps confirming the notion that parents experience a spoiled identity. As mentioned in Chapter 3, parents of children who are considered 'abnormal' are reported to share in their child's stigma and

marginalisation (Harden, 2005; McKeever and Miller, 2004; Gray, 2002a, 2002b; Goffman, 1990). This 'undesired differentness' (Holt, 2010:416) that being a parent of a child with ADHD brings has implications for parents' identities and this needs to be carefully managed. One of the ways that the parents in this study manage this is through accounts which normalise their parenting practices, which is the focus of this final section on mothers.

7.4 Constructing normality

As mentioned in Chapter 3, parents of 'troublesome' children are positioned within distinct categories of parenting. They are members of the general category 'parent' and of the particular category 'parent of a child with ADHD'. Their identities (as parents) can therefore be constituted from drawing upon both the repertoires of 'ordinary' parenting, and from repertoires of 'abnormal' parenting.

Clearly, being understood as an 'ordinary' member of an 'ordinary' category aligns an individual with a commonly accepted social norm. 'Doing being ordinary' is a common discursive strategy used to perform specific rhetorical business (see Sacks, 1995). In presenting ourselves as ordinary, non-exceptional members of the groups to which we belong, or in which we participate, we are not required to account for our actions (Locke and Edwards, 2003). Voysey (1972) suggests that families of disabled (sic) children sought to minimise the distinctiveness of their child's disability because claiming ordinariness protected them from scrutiny and intrusion by professional experts. By minimising difference, membership is not called into question, and, arguably, moral integrity remains robust. In making relevant the subject position of the 'ordinary' mother, the moral identity of these mothers is hard to challenge, as 'ordinary' mothers are understood to be 'good' mothers. Certainly, this seems to be borne out by several studies. In particular, Todd and Jones (2003) found that in their dealings with professionals, mothers

typically presented themselves as caring, 'ordinary' mothers, just like 'any other'. This, they argue, is one way mothers resist being pathologised along with their children.

The representation of self as 'ordinary' is achieved through discursive practices and can be understood as a discursive accomplishment (Holstein and Gubrium, 2000; Sacks, 1995; Widdicombe and Wooffitt, 1995; Wooffitt, 1992; Pollner, 1974). The following examples examine how mothers 'do being ordinary' and to what rhetorical effect.

In Extracts 9 and 10, Donna and Jane are talking about the parenting classes that they have been advised to attend.

Resisting the need to change parenting practices

Extract 9, Donna (Focus Group 1)

Donna: *you get to that point and I did that and I actually found that I was helping other parents in the group or they were snatching ideas off of me they actually turned round to me at the end and said 'if we had more parents like you we'd' (laughs) ...well, anyway [...] I enjoyed it the bit I got out of that most was meeting other parents with the same problem*

Extract 10, Jane and Alan

Jane: *any anything I went I was going on one in January for twelve weeks specifically for ADHD and for challenging behaviour and there wasn't a lot of practical help it was more revisiting sort of what it is you know about self esteem confidence (laughs) you know sort of all these things that you know they have cause and effect what you want to know is how to deal with them and I came away and we sort of we've come to the conclusion really that what we're doing is*

probably all you can do and there isn't a magic answer out there and you know...

Similar to Ingrid in Extract 8, Jane and Donna's accounts work to dismiss the need for them to attend parenting classes. However, whereas Ingrid's basis for resisting parenting classes lay with her son's difference (or 'abnormality'), the basis for Jane and Donna's resistance is because they already practise the skills of good parenting, and, therefore, there is nothing new to teach them. This resonates, once again, with Holt's (2010) findings and is illustrative of how mothers manage the double bind of being seen to engage with such classes, but also resisting the need to change their parenting practices. Both Donna and Jane claim the subject position of the good mother through their identification with the parenting expertise taught at these classes. In Jane's case, the classes reassure her that there is nothing new that she (and Alan) can learn regarding her son ***we've come to the conclusion really that what we're doing is probably all you can do and there isn't a magic answer out there***. The use of the general pronoun 'you' in Jane's ...***probably all you can do***... implicates all members of the category of parent, as well as building an affiliation with the listener (Sacks, 1995). It thus appeals to a common-sense understanding that Jane and Alan are doing what any 'ordinary' parent would do. Indeed, Jane's conclusion that there is no 'magic answer' strengthens her appeal to ordinariness.

Donna's assessment of her parenting classes is more complex. She works to construct herself as an ordinary parent, by aligning herself with the culturally, and morally, appropriate parenting skills sanctioned by the experts, and also by distancing herself from the other parents in the group, who she constructs as less capable and morally worthy. At the beginning of the extract, she aligns herself very firmly with the experts: ***I was helping other parents in the group or they were***

snatching ideas off of me they actually turned round to me at the end and said 'if we had more parents like you we'd' (laughs) ...well, anyway. Donna's input into the group is constructed as helpful and worthy. Her description of the other parents ***snatching*** her ideas from her, implies their lack of parenting strategies, and also suggests their morally inappropriate behaviour. 'Snatch' is a morally 'weighted' word, in which desperation and neediness are implicated. Further suggested by the word snatch, is that Donna, was 'full' of ideas whereas the others had none of their own. Donna provides the experts unfinished reported assessment of her: ***'if we had more parents like you...well, anyway...'*** Although the sentence is unfinished, it is clear that it is the beginning of a compliment about Donna's parenting. However, in not finishing the sentence, Donna also manages to convey her modesty. The somewhat dismissive ***well, anyway*** establishes Donna as 'non-boastful' and works to accomplish her modesty (McMullen, 2005), while at the same time establishing her position as a good parent. Once Donna has established her credentials as a skilled, ordinary, parent, who is praised by the parenting experts, she can then align herself with the other members of this parenting group, because this next turn can be heard as a further display of modesty: ***the bit I got out of that most was meeting other parents with the same problem.*** Learning 'new' strategies is not what Donna took away from the sessions, presumably, because there was nothing new to learn. Through 'doing modesty' (McMullen, 2005) Donna occupies two contrasting, yet 'ordinary' positions: an ordinary member of the parenting group, but, crucially, a member who aligns herself with the expertise that comes from being an 'ordinary', but skilled parent.

As discussed in Chapter 3, there is a moral imperative for mothers to 'cope' with and accept their children's condition (Bull and Whelan, 2006; Harden, 2005; Litt, 2004; Gray, 2002b; Segal, 2001). As we have already seen in this chapter, the

good mother subject position is made relevant through accounts of coping with extreme and abnormal behaviour. In the next few extracts, the good mother position is made relevant through accounts of mundane, or everyday, coping and acceptance. In the two extracts that follow, the mothers mention the importance of humour as a coping strategy.

Laughing in the face of adversity

Extract 11, Kim

Kim: *but afterwards it's hilarious and that's how I have to see it I have to try and say at the moment 'this will seem funny later' (laughs)*

Alison: *(laughs) not fun at the time no*

Kim: *a good sense of humour is definitely needed [with these children] (laughs)*

Extract 12, Julie

Julie: *very much yeah I think you go through the experience and sort of get a bit stronger for it and when you use we've got (unclear) we use humour you know to deal with the things that he does cos you have to laugh at some of the things he does cos otherwise the alternative is to cry at them but yeah just try maintain a sense of humour with them and ...*

Both Kim and Julie's extracts come at the end of lengthy accounts of a 'toilet mishap' (Kim) and of experiencing judgement from a head teacher (Julie). Both stories, in their own way, are poignant and harrowing and it is interesting that they both end with Kim and Julie's assertion that humour is a necessary requirement when dealing with a child with ADHD. This resonates with Radley and Billig's (1996) findings that patients worked to represent themselves as 'good patients' by claiming normality in their accounts of health and illness. One way of accomplishing a 'normal or ordinary' identity is by making the extraordinary,

ordinary; in this case, by 'laughing it off'. It can be seen that mothers represent themselves as 'good' mothers by claiming normality in their accounts of their experiences of their children. In constructing an 'ordinary' identity, these mothers can be understood as not complaining or asking for special treatment, which would potentially risk their positioning as sympathetic figures. Additionally, the mothers can be seen to be redefining their 'misfortune' in a positive way, which also works to formulate them as having 'strength of character', and, once again, accords them a moral integrity and worth (see Radley and Billig, 1996:227).

Another way of demonstrating a positive attitude to their circumstance is by reframing their children's behavioural characteristics in ordinary and more positive terms as Gill does in the following extract:

Extract 13, Gill and Mick

Gill: *I actually find him quite funny, a little comedian and he's really quirky and he's full of beans and he's wild [...] so with him I find no problem at all I quite enjoy it he's very spirited he's good fun*

Gill reformulates the negative terms typically used in descriptions of ADHD behaviour with synonyms which carry very different connotations. The problematic hyperactivity normally ascribed to children with ADHD is described here in terms of being **full of beans** and **spirited** and any claims to 'abnormality' are reconstituted as **quirky**. This description could be of any 'ordinary' child. In constructing her son in ordinary terms, Gill is demonstrating her unconditional acceptance of her son, as any good mother would. In addition, in constructing her son's ordinariness, she is constructing her own ordinariness as a mother. As Holstein and Gubrium suggest (2000:210), 'when the child functions normally, the parent, for all practical

purposes, is taken to be a normal parent', their parenting identity is not in need of account or explanation.

Demonstrating acceptance of the child is a frequent concern of the mothers in this study. One way in which this is accomplished is by working up accounts which suggest there is a 'fit' between the child and the family. The following two extracts illustrate this:

Resisting the 'tragedy' story

Extract 14, Gill and Mick

Gill: *...I think even when I was pregnant with J we were doing this little magazine questionnaire and it was 'what kind of child would you like?' and we both said we would like somebody who is spirited*

Mick: *uhm*

Gill: *and my God we got it (laughs) [...] and that sort of sticks in my memory*

Mick: *hmmm hmm*

Gill: *we actually out of choice we said [...] 'no we want somebody quite dynamic and spirited and we got that'*

Mick: *yeah I we didn't want a wallflower we wanted somebody who's quite [...] 'cos we're both reasonably ebullient ourselves*

Gill: *and I 'm happy that we got that [...] he's he's going to do great he's going to be brilliant he's going to [...] get a career and whatever he wants*

Extract 15, Kim

Kim: *uhm (pause) I don't know uhm I sometimes feel that it... on the whole I feel quite positively about it really because I think we can deal with it uhm so in that way I'm sort of glad he's born into our family cos we're equipped to deal with it*

so I'm pleased for him because it would be so much worse if he (laughs) was in a chaotic uhm and because he's the first he's sort of lead the way so in some ways the whole family without meaning to everything revolves around him and he we're sort of lead by him we don't do the restaurants much and the coffee shops or anything but because we never did that before him it's not such a...

Both Kim and Gill talk in positive terms about 'having' the child they do, and both account for this in terms of a 'fit' between their son and their family. As Gill says: ***we said [...] 'no we want somebody quite dynamic and spirited and we got that'***. Their son's character 'fits' with their own ***ebullient*** natures. Kim says she is ***sort of glad*** that her son is with her family because she feels that her family ***are equipped to deal with it***, and are less ***chaotic*** than (presumably) other families. The ordinariness of her family is implied as a reason for providing a suitable environment for her son. This family 'fit' resonates with Broberg's (2011) findings in relation to expectations of and reactions to disability and normality experienced by parents of children with intellectual disabilities. One of the prevalent parental reactions identified in his study was to frame acceptance of their children's difference within a repertoire of belonging. This, Broberg (2011) suggests, is a way of resisting the social and cultural expectation that families of biologically 'atypical' children will feel sad and bereaved (see also Watermeyer, 2009; Goodley and Tregaskis, 2006). Such families are frequently positioned within a dominant 'tragedy' narrative. This 'tragedy' narrative is potentially compounded by the research situation and implied through the interview process (Swain and French, 2000).

Arguably, being members of a parenting 'support' group confers certain category-bound attributes, duties and obligations (see Stokoe, 2003; Widdicombe and Wooffitt, 1995; Sacks, 1995) that are constitutive of the category itself. In this

case, parental identities are formulated in relation to their own needs to cope with their child's biological 'abnormality'. The categorisation of 'a parent in need of support' potentially establishes a deficit account of family life when compared against the norm. These parents are in need of support (help?) in some way because their lives are different and difficult. The parents in this study were approached to participate through contacting support groups. They were, subsequently, invited to talk about 'their experiences' of parenting a child with ADHD and even though the interviews undertaken in this study were as unstructured as possible, to ensure that parents were as 'free' as possible to provide their own accounts, the method of recruitment and the setting up of the interview to talk about 'experiences of parenting a child with ADHD' (rather than just 'parenting') formulates these parenting experiences as distinct and out of the ordinary.

Following ethical guidelines, all the interviews were set up with attendance to the possibility that talking about such experiences might be a sensitive issue and this was made clear to participants in the contract stage prior to the commencement of the interviews. All participants were reminded that they only need disclose information they felt comfortable sharing. It is very possible that the excessive concern with sensitivity, causing undue harm and establishing a protective contract set up a context which positioned these parents as fragile, and the topic of ADHD as sensitive (or even tragic). As Corbin and Morse (2003:337) comment 'to make the assumption that all interviews are potentially harmful takes away participant agency and control over what is said, how it is said, or if anything is said at all about a topic'.

All the interviews and both focus groups began with harrowing accounts of misdiagnosis or difficult behaviour, suggesting that mothers rhetorically orient to

the interactionally occasioned expectation that accounts of their parenting experience would be of hardship and distress. It is only after providing these distressing accounts that mothers turn to more positive and 'ordinary' accounts of their experiences. Gill and Kim's accounts of acceptance of their child, similarly, come after lengthy descriptions of difficulties and hardship. Wilkinson and Kitzinger (2000) suggest that one of the functions of 'positive' talk is to 'close down 'troubles telling', while making it possible for troubles telling to take place'. Finishing on an 'upbeat' note protects both the speaker and the listener from a potentially difficult and awkward interactional moment.

The biological repertoire potentially, makes available a deficit account of child behaviour. As inferred by the DSMV (American Psychiatric Publishing, 2013), ADHD behaviour can be identified by comparison with developmental 'norms' (McVittie, Goodall and McKinlay, 2008). A deficit account of developmental appropriateness makes available a 'tragic' subject position for the child and for the family. Medical abnormality and sickness, inevitably, confer sympathy on the individual in question, and this is extended to the family, and where children are concerned, especially to the mother. Clearly, in the face of so much public ambivalence to ADHD, the biological repertoire is an appealing one for mothers to take up. However, in taking up the biological repertoire, the biologically 'abnormal' child, becomes the focus of institutional 'sympathy', an object of regulation, scrutiny and intervention, and this too extends to the family. Positioning individuals within a 'tragic' narrative, potentially risks formulating them as lacking in 'ordinary' worth; they have to be related to differently, and are accountable for their actions (as in being invited to participate in research interviews). As we have seen repeatedly throughout this and the last chapter, it is extraordinary phenomena that need to be accounted for; ordinary, everyday life needs no account. The 'tragic' story also diminishes the possibility for agency, which, as discussed in the last

chapter, is very much implicated with the construction of maternal responsibility and moral worth.

Clearly, therefore, one way for parents to resist the tragedy narrative is through emphasising the normality of their family life, and, in particular, through according little significance to the actual biological 'difference' of their child. Broberg (2011) considers that through emphasising ordinariness, parents assume an active subject position, one which permits them the possibility of 'normality, involvement and mastery' in relation to their parental duty of care. Certainly, Gill's final comment regarding her son that: ***he's he's going to do great he's going to be brilliant he's going to [...] get a career and whatever he wants*** is defiant of any suggestion that he will assume the 'tragic' subject position of an ADHD 'victim'. In declaring her confidence in him, she defies the 'tragic' narrative, whilst also presenting her 'good mother' credentials through her unfailing faith in his anticipated future (see Blum, 2007; Backett-Milburn and Harden, 2004; McKeever and Miller, 2004).

Kim's extract is a little more problematic evidenced through her use of hedging devices and modifying phrases to minimise the strength of her acceptance (the modifiers are underlined in this example): ***I don't know uhm I sometimes feel that it... on the whole I feel quite positively about it really because I think we can deal with it uhm so in that way I'm sort of glad he's born into...*** The hesitancy and vagueness of Kim's account of acceptance of her son may indicate the dilemmas around health, illness and maternal responsibility referred to in the last chapter. Although there is a moral imperative to think positively with regard to health and illness (Wilkinson and Kitzinger, 2000; Radley and Billig, 1996), this is problematic for a 'devoted', ordinary mother, who would wish no 'harm' or 'hardship' on their child. Additionally, the moral imperative to think 'positively' does not really permit a 'good' mother to express ambivalence about her child when the

culturally dominant message is that a good mother loves her child unconditionally, 'warts and all'.

Kim's description of acceptance of her son is not to be understood as a straightforward representation of her attitude to him. Rather, her hesitant account should be understood, like all the accounts of these mothers, as an example of them making sense of their lives and experiences in the everyday negotiation of their own and their family identities. As McVittie *et al.* (2008) suggest, the identities constructed by the mothers in this study should not be treated as static or externally verifiable entities, but as a 'participants' resource' to be drawn upon when attending to the 'practical concerns and on-going negotiations' of the immediate context. The changing ways in which mothers talk about their experiences is indicative of the very complex ways in which mothers 'negotiate and understand their children' (Goodley and Tregaskis, 2006) within the shifting demands of the local interaction.

7.5 Summary

This chapter has focused on the secondary binary position available for mothers; the valorised mother subject position. It has demonstrated how mothers are constructed as good, valorised mothers through accounts that work up abnormality and then, conversely, through their attempts to normalise their experiences. Abnormal and normal parent/child dynamics are formulated to construct different maternal identities, typically relating to themes of coping and managing, but all of which, make relevant the good mother subject position.

The chapter that follows explores how fathers construct themselves as good fathers by making relevant those 'good father' subject positions that are made available through distinct repertoires of ADHD.

Chapter 8 Constructing the good father

As outlined throughout this thesis, there is very little literature written about fathers' moral accountability vis-à-vis their children, and also very little written about fathers of children with ADHD (exceptions include Gray, 2008; Singh, 2003). This chapter discusses how fathers orient to the subject positions made relevant by the two repertoires of ADHD, and how, in so doing, they accomplish their own moral adequacy as good fathers. It is divided into three main sections; first, it examines how fathers draw on traditionally valued gendered subject positions, then it looks at the take-up of subject positions which legitimise fathers' entitlement to expertise and knowledge. Finally, the chapter discusses how certain subject positions permit fathers to both identify with and distance themselves from the ADHD label.

8.1 ADHD and gendered subject positions

ADHD, as both a social phenomenon and a topic of research, makes gender a relevant concern (Horton-Salway, 2012; Bailey, 2009). In terms of research, the focus has traditionally been on mothers and sons (Horton-Salway, 2012; Blum, 2007; Singh, 2002a, 2004), and, typically, on 'problem' boy and 'problematic mother' (Singh, 2002a:581). In terms of wider discourse, coverage of ADHD in the UK newspaper media highlights the gendered nature of subject positions (Horton-Salway, 2012, 2011). Fathers, for example, are typically positioned in relation to debates about the association of ADHD with a contemporary lack of parental (father) discipline. Specifically, this perceived 'lack' of discipline is contrasted unfavourably with the 'old fashioned discipline' of the past (Horton-Salway, 2011:543). Declining paternal authority as a wider discourse of concern is one that is also identified within sociological literature (Barnes and Power, 2012; De Benedictis, 2012; Yarwood 2011; Gillies, 2005).

Similar to Gray's (2008) findings, the 'disciplining' and 'strict' father are subject positions that are made relevant by all of the fathers in this data set. Extracts 1 and 2 are examples of how fathers, in rhetorically orienting to prevalent representations of parents of children with ADHD as lacking in disciplinary presence (Horton-Salway, 2011; Gray, 2008), make relevant the gendered subject position of disciplining father. The disciplining father works to resist possible claims that their children's behaviour is caused by an absence of discipline in the home and so also works to manage the moral accountability of these fathers in relation to their sons' ADHD and their identities as good parents (see O' Reilly, 2008 for further discussion of discipline as a discursive strategy).

8.2 Constructing disciplinary presence

The following extract comes from the first focus group, at a point where the group is discussing discipline and the management of their children's behaviour. John explains how he and Ingrid (his partner) manage discipline and the extract illustrates how the gendered subject position of the authoritative father who 'does the discipline' is made relevant by this father.

The disciplining father

Extract 1, John

John: *well the way we work that's it it's just the threat of a smack. I'm used as a threat 'right if you don't do that then I'm going to call daddy' and that's it as soon as I walk in the room 'oh dear now I know I'm in trouble' it's it's that threat of 'yes ok Daddy's here'*

In this instance, John constructs himself as having a disciplinary authority over his son. The use of the word 'just' in ***it's just the threat of a smack*** works in two ways. First, it softens the potentially problematic concept of 'smacking' his son; the

implication being that he does not have to smack his son. The threat of a smack is sufficient to curb his son's behaviour. This is particularly important at this juncture in the focus group as the group has just been undermining a disciplinary approach to managing their children, typically, advocated by grandparents. However, the word 'just' also works to emphasise John's authority over his son; all that is needed is a threat of a smack. Indeed, John continues this extract by describing how his presence alone has an effect on his son; his presence is 'threat' enough: ***it's that threat of 'yes ok daddy's here'***. His disciplinary authority is corroborated by John's active voicing (see earlier) of what Ingrid says ***'right if you don't do that I'm going to call daddy'***.

John's subject position as an authority figure is also made relevant by him and Ingrid during their interview. In the following extract, their co-construction works to position him as the firmer, stricter parent.

The stricter parent

Extract 2, Ingrid and John

Ingrid: yes 'cos sometimes you don't know if you if you you know sometimes you'll say
'ah well I'll let him get away with it because he has ADHD' but then I think 'well
actually no it's still not acceptable' but it's really difficult...

John: 'yeah I'll set fire to the building but I've got ADHD'

Ingrid: yeah I find it very hard to draw the line

Alison: I think that would be really hard I can imagine that

John: well it's a case of pushing the mark isn't it? you push the mark and then if
you're going to keep trying to push the mark then you've got to put a stop to it
as far as I'm concerned I mean I've got I've got very strict boundaries of

*behaviour and this that and the other and I'm being right or wrong I don't care
if you've got ADHD ABC or 123*

Ingrid: *(laughs)*

John: *at the end of the day 'behave yourself' that's it you know you push the mark
once don't do it again simple as that*

Ingrid: *but he definitely pushes a lot more with me*

John: *oh he does with you yeah*

Ingrid begins this extract by suggesting that discipline can be problematic for parents of children with ADHD when deciding which behaviour can be accounted for by the (medically abnormal) condition of ADHD, and which behaviour can be accounted for by the child's normal naughtiness. The implication that Ingrid is making available is that each require different parenting responses. John follows Ingrid's turn with an ironic rejoinder **'yeah I'll set fire to the building but I've got ADHD'**. In contrast to discursive devices which work to reify descriptions, the use of irony works as a device to deconstruct the factual truth of description (Potter, 1996; Speer, 2002). Ironising discourse undermines what might be understood as factual or typical, and turns it 'back into talk which is motivated, distorted or erroneous in some way' (Potter as cited in Speer, 2002:368). Here, the use of irony immediately following Ingrid's admission that she is more lenient because the child has ADHD, works to construct this position as an erroneous one; one that John does not share. John, thus, distances himself from a common perception that having an ADHD diagnosis serves to absolve children (and by association parents) of responsibility for their actions. This point is emphasised again with John's ironic conclusion to this sentence: ***I've got very strict boundaries of behaviour and this that and the other and I'm being right or wrong I don't care if you've got ADHD ABC or 123***. John makes it clear that whatever the

medical label, he will not be taken in by it and will not use it as an excuse for his son's behaviour.

Throughout this extract, John constructs himself as a firm father with firm boundaries. His use of the second person plural pronoun 'you' in: ***you push the mark and then if you're going to keep trying to push the mark then you've got to put a stop to it*** invokes common knowledge and works to establish his behaviour as unexceptional, routine, and, in this case, reasonable (Clarke, Kitzinger and Potter, 2004; Edwards, 1997). Clarke *et al.* (2004) suggest that appealing to common knowledge of what would be generally applicable standards builds affiliation between a speaker and their audience, and can be an indicator of the speaker's orientation to possible individual criticism. John is working to avoid any suggestion that his individual approach to discipline is wrong by invoking a general formula. The issue of discipline is a 'matter of public debate and disagreement' (see Billig, 1996) and it can be controversial to advocate particularly firm parenting styles, particularly, if the child's troubling behaviour can be accounted for medically, as in this case. John's invocation of his own personal disposition to discipline ***as far as I'm concerned I mean I've got I've got very strict boundaries of behaviour*** is tempered by his appeal to common understanding that his tendency to discipline is what anyone would do under the circumstances. In that way, he cannot be accused of being overly strict.

John's construction of himself as a firm father is corroborated by Ingrid, and, indeed, work is done by both Ingrid and John to establish John as the stricter, firmer parent. John's non-negotiable stance with regard to his son's behaviour contrasts with Ingrid's description of her own dilemma at the beginning of the extract. For her, knowing when to discipline or when to ***let things go*** is a difficult

choice: *I find it very hard to draw the line*. For John, however, it is a case of *that's it you know you push the mark once don't do it again simple as that*.

Ingrid's claim that their son *definitely pushes a lot more with me* is accepted without debate by John *oh he does with you yeah*. John's response constructs what is said as routine and uncontroversial; it is a statement of fact and not an issue of contention (Billig, 1996). In this way, it orients to gendered parenting roles. There is no challenge to the construction of the mother as the 'softer' parent. It is taken-for-granted and uncontentionous.

The co-construction of John as the firmer parent is immediately followed (see Extract 3) by orienting to a further gendered subject position of Ingrid as the 'stay at home' mother with another child to look after, as well as being pregnant with a third. This functions to mitigate Ingrid's softer parenting as completely understandable in the context of her role. The 'stay at home' mother subject position is also made relevant in Alan and Jane's interview (Extract 4).

The out at work father

Extract 3, John and Ingrid

Ingrid: *but he definitely pushes a lot more with me*

John: *oh he does with you yeah*

Ingrid: *I I do find it hard to ...*

John: *but then you've got R as well and then you've got the little one on the way as well and I'm at work I don't envy you*

Extract 4, Jane and Alan

Alan: *yeah and he still plays us off against each other*

Jane: *oh yeh*

Alan: *and it's 'oh well I'll ask mummy cos I always get it mummy's an easier tar ...*

Jane and Alison: *laugh*

Alan: *cos you let things go more than I do isn't it? Whereas I've probably got a diff...
my criteria... cos I'm not there all the time I'll think him eating with a knife and
fork for me is ...*

Jane: *everything is a compromise with him*

John's description of Ingrid's situation invokes the relevant category membership (Sacks, 1995; Edwards and Potter, 1993) of being a busy mother with her hands full. As Edwards and Potter (1993) argue, the use of descriptive categories imply attributional responsibility for actions; they are ways of externalising and, thus, accounting for behaviour which suggest that 'anybody or everybody in those circumstances, in that role, did or would have acted that way' (Edwards and Potter, 1993:35). In implying Ingrid's membership of the category 'mother', John is accounting for Ingrid's lesser disciplinary presence. The implication is that, because Ingrid, as a good mother, has got her hands full, it is understandable that she cannot be as firm a parent as John can. John's use of category membership in this instance works rhetorically to both establish Ingrid as a good, and dutiful mother, at the same time as mitigating her 'deficiency' in disciplining her son and also to reinforce the construction of himself as the firmer parent.

Both John and Alan index their respective partner's subject position of 'stay at home mother' with their own of 'working father. Ingrid's lack of disciplinary presence is compounded by John's not being there: **and I'm at work**. Alan's explanation for why he does not **let things go** is **cos I'm not there all the time**, the implication being that Jane is 'there' all the time, and that is why she 'lets things go'. Supporting findings by Riley (2003) and Lupton and Barclay (1997), the fathers construct traditional female roles as relevant and important. However, the

indexicality of these traditional and gendered mother/father subject positions is also drawn upon to accomplish moral accountability; the two positions of 'out at work' versus 'stay at home' are rhetorically invoked to account for John's (and Alan's to a lesser extent) role as the ultimate deterrent and to mitigate a 'deficiency' account of (Ingrid's and Jane's) routine parenting.

As Lupton and Barclay (1997) suggest, fatherhood and motherhood are interrelated; each category draws meaning from the other. In linking a lack of disciplinary presence with staying at home with the children, the position of 'disciplining father' becomes associated with the father who is away from home all day, the working father.

Although, as indicated in Chapter 3, contemporary discourse makes available alternative versions of fatherhood (Yarwood, 2011; Featherstone, 2009; Robb, 2004a, 2004b; Lupton and Barclay, 1997), which the fathers in this data set do indeed draw upon, the subject position of 'disciplining father' is one that is consistently made relevant, even when resisting it. The subject position of ineffective parent, made available through psychosocial explanations of ADHD, is, arguably, so pervasive that the 'giving up' of the disciplined father position is one that necessitates accountability and justification as demonstrated in the following two extracts.

Giving up the disciplined father subject position

Extract 5, Mick and Gill

Mick: *because of my background and because of who I am you know... I wanted to be... I thought I was going to be very disciplinarian (smacks hand) you know but that just doesn't work it took a while for me to work that out [...] well the way I*

th... I always thought I'd bring up children is fairly strict not brutally strict just firm very firm

Gill: *this is before you had children*

Alison: *(laughs)*

Mick: *before I had children yeah and I think when anybody has children suddenly realises oh it's not quite what I thought you know and I...I... it's not there's not one set of rules it doesn't work that way and uhm and yeah me trying to be this s...strict person for the... for the... for the... wanting to do the best for my children by going out ...uhm and it wasn't working and I thought 'agh' you know...and he 'why is he being like this why can't he just do as he's told?'(laughs) and he never will [...]*

Gill: *but I I think you found it hard to think you went into parenting with this...without the J... 'this is how I will be' or you know 'if you do this the child will have to respond' uhm you kind of have to be adaptive*

In extract 5 Mick and Gill, work to undermine discipline as the only approach to parenting children with ADHD. This is a potentially risky attitude to express as it could be understood that Mick and Gill lack disciplinary presence, and might be an indicator of weak parenting. However, both extracts use a before/after pattern which resembles the discursive device 'at first I thought...but then I realised' (see Chapter 4) ***I wanted to be ...I thought I was going to be very disciplinarian you know [...] but that just doesn't work and I always thought I'd bring up children [...] fairly strict [...] before I had children yeah and I think when anybody has children suddenly realises oh it's not quite what I thought...***

This device is used to construct the speaker as reasonable and reliable, but events as unusual. The speaker's mundane and original version of events is challenged by empirical facts (that is, his son's ADHD). The use of the second

person plural 'you' in **you know** works to construct Mick's preconceived expectations of what he would be like as a father as universal and mundane (see the earlier discussion of the generalised 'you'). His expectations of fatherhood, however, were challenged by the reality of having children, and, crucially, a child with ADHD. The discursive device does several pieces of work; it inoculates Mick from being seen as a weak father, and it also shows that Mick has a flexible approach to parenting and a willingness to learn, a further demonstration of good fathering. The undermining of a more disciplined approach is also justified by Mick, and Mick and Gill, through constructing their entitlement to epistemological warrant (see Chapter 5). Mick's initial disciplinarian stance is constructed as being uninformed due to lack of parenting experience:

Mick: *well the way I th...I always thought I'd bring up children is fairly strict not
brutally strict just firm very firm*

Gill: *this is before you had children*

Once he becomes a parent, specifically, a parent of a child with ADHD, then he is entitled to give up his approach to discipline as it clearly **just doesn't work**.

In Extract 5, Mick and Gill construct Mick's attitude towards discipline and parenting as having changed, which resonates with Lupton and Barclay's findings (1997) that fathers construct their experience of fatherhood as being transformative. There is no sense here that Gill's stance towards discipline and parenting has changed. Indeed, Gill gently mocks Mick's expectations that he would be a firm father and this works to distance herself from this position; the unspoken implication is that she had more realistic expectations. Again, traditional gendered subject positions, although implicit, are made relevant. Although Gill does not describe her own expectations, her description of Mick's initial approach to parenting is indexically constructed to imply a naivety that hers did not: **I think**

you found it hard. Mick's approach to parenting is provided as an instance of a 'particular' (atypical), naïve approach to parenting. By not describing Gill's approach to parenting, her approach is constructed as the 'typical', normatively shared one (Billig, 1996; Edwards, 1991). The implication is that parenting was instinctive and natural for her, but that it was something that Mick had to learn. Indeed, in this extract, Gill seems to take on the role of teacher as she advises ***you kind of have to be adaptive,*** which resonates with Lupton and Barclay's (1997) description of the teacher/learner roles that mothers and fathers respectively adopt.

In contrast to the 'deficiency account' of mothers' parenting (in terms of their disciplinary presence) in Extracts 3 and 4, Gill's approach to parenting and discipline is constructed as the more realistic one here, and, consequently, has implications for Mick's own positioning. The disciplining father subject position is constructed as unrealistic and naïve, and, as such, is justifiably given up.

The disciplining father is not the only gendered subject position which is made relevant by parents in this data set. Another very traditional version of fatherhood which is made relevant is that of the emotionally strong father. The subject position of emotionally strong father, with its connotations of resilience and self-control, serves as a rhetorical and moral rejoinder to the more instinctive and labile emotions attributed to the mother. This subject position is also drawn upon to corroborate factual descriptions of how tough, exhausting and exceptional certain experiences related to having a child with ADHD can be, and to illustrate that despite everything, parents, and, in this instance, fathers, are coping and able to manage their children.

8.3 Constructing emotional strength

Extract 6, taken from John and Ingrid's interview, is an example of how the construction of the emotionally strong father is accomplished. John and Ingrid have just been talking about how they felt everybody believed them to be bad parents and the researcher has responded that that must have 'got to them'.

The emotionally strong father

Extract 6, John and Ingrid

John: *yes it did and as I say it's only for myself uhm I'm very sort of stubborn and strong-minded but even for me yeah it did get me down*

Alison: *yeah it must*

John: *and I know for a fact it got Ingrid down because as I [said she was in fits of tears]*

Ingrid: *[there was times when] I just I just burst and I just couldn't uhm*

John: *couldn't cope with it*

Alison: *no I'm sure*

Ingrid: *no and we've always said I mean luckily we got you know we're quite I'm we are very strong and I mean I am quite strong I can take a lot it takes a lot to (unclear) me*

John: *yeah you can [...]*

Ingrid: *and we had really good... thank God we have very good ...we work together very well you know we never blame each other you know we've always supported each other but if we weren't these people we would have broken a long time ago*

Alison: *no I'm sure*

John: *and I can ...I can see people out there that it would have destroyed them
basically ho...ho...honestly I can*

Alison: *yeah yeah*

John: *'cos you know because there are a lot of people out there who aren't that
strong and even for me (laughs) I've gone to the border line with it and you it
even broke you and you as you say you're a very strong person I know that but
yeah...*

Ingrid: *it comes it comes it just comes to a point but then you need to get over that and
then you start over again*

John: *of course but that's that's what we do*

Ingrid: *yeah*

John: *but as I say there are some people out there where they can't*

In this extract John is describing the period leading up to getting a diagnosis. He is working up an account of how tough the situation was for them prior to diagnosis, and this description, in part, works as a justification for their persistence in seeking a diagnosis. Emotional discourse is used to construct the extremity of the situation. In particular, John rhetorically contrasts his own stoical disposition with the event-driven emotion of the circumstances being described (Edwards, 2001). At the beginning of the extract, John uses stake inoculation (Potter, 1996) to undermine a possible interpretation of him as being prone to emotional exaggeration: ***I'm very sort of stubborn and strong- minded but even for me yeah it did get me down.*** John's use of 'even' in: ***even for me yeah it did get me down*** works to confirm the emotional impact of the events described: his emotional disposition would predict that he could cope with most situations, but these events exceeded all expectations. In this extract, work is done to both build the emotional truth of the narrative and to construct John's emotional strength.

John constructs his own strength by contrasting it with the imagined response of others and also, crucially, by indexing his responses against those of his wife. John's somewhat understated description of his own response to events ***it did get me down*** contrasts with the more extreme language that he (and Ingrid) use to describe Ingrid's response ***she was in fits of tears; I just burst; it even broke you*** and the imagined response of other people ***it would have destroyed them basically***.

In this study, description of fathers' emotional stoicism is often contrasted with descriptions of mothers' emotional 'breakdown'. These gender positions are, typically, co-constructed in this data set. Indeed, in this extract Ingrid accepts John's description of her being in ***fits of tears*** and expands on it ***there was times when I just burst and I just couldn't uhm...*** Ingrid hesitates at the end of this sentence, but, presumably, she was going to continue with a sentiment similar to the one expressed by John ...***couldn't cope with it***. This construction of gendered patterns of emotion, echo findings by Seymour-Smith and Wetherell (2006), which suggest that within heterosexual couples, emotions are typically 'done', or carried, by the women. Men, on the other hand, are constructed as strong and supportive, which resonates with the 'sturdy oak' representation of masculinity as identified by Pleck (1987) and cited in Seymour-Smith and Wetherell (2006). A similar pattern of emotional 'work' is also identified by Doucet (2006), who suggests that worry about children is externalised by mothers and internalised by fathers.

Although John concedes to an emotional response, it is represented as being a restrained and controlled one. Lupton (1998, cited in Wetherell, 2012:94), suggests people's narratives are inclined to focus on 'oppositions between natural emotion and reasoned control'. Narrative accounts of the control of 'natural'

emotions, she argues, are constructed as the sign of a rational person. John hints at his 'natural' emotion: *it did get me down* and *I've gone to the border line with it*, which works to construct him as caring and sensitive. However, predominantly, the quality that he conveys of himself is one of emotional control. This contrasts with Ingrid's less controlled 'natural' emotion.

Emotional 'breakdown' is a potentially risky area for parents of children with ADHD. In admitting to not coping with their children, parents might risk positioning themselves as being feeble or ineffective. In drawing upon the subject position of emotionally strong father, John makes clear that, although pushed *to the border line*, he was able to cope. Similarly, Ingrid's hesitation at admitting she could not cope might be an indication that this is a troubling statement. It is interesting that in response to John's assertion that she 'couldn't cope', Ingrid begins repairing this possible understanding of herself: *we are very strong I mean I am quite strong*. However, even here, her strength is contingent upon John's. Together they are *very* strong, alone, she is *quite* strong. Crucially, their parenting teamwork is co-constructed as strong and this is achieved by shifting the focus from John and Ingrid as individuals, to them as a team. Discursively, they move from talking about 'I' and 'you' to 'we' and contrasting their combined strength with the constructed 'weakness' of generalised others. As John says, *and I can ...I can see people out there that it would have destroyed them basically [...] there are a lot of people out there who aren't that strong*.

The use of emotional discourse in this extract establishes that the requirements of parenting an ADHD child are exceptional and abnormal, but that John's emotional resilience (and Ingrid's, with John's support) enables them to cope.

So far this chapter has examined how fathers resist being positioned by the psychosocial repertoire as 'morally' weak by taking up the subject positions of

disciplining father and emotionally strong father. Both of these positions are implicated with traditional notions of masculinity, and, arguably, in many contexts, quite out-dated notions of fatherhood. As such, they are potentially risky positions to adopt. However, despite this, all the fathers in this study oriented to these subject positions in their accounts of their experience of being a father of a child with ADHD (as did the fathers in Gray's study, 2008). The subject positions of disciplining father and emotionally strong father have rhetorical and even political currency. Discipline, in particular, is a contentious issue and a matter of public controversy (Billig, 1996). Debates about the effect of a lack of discipline versus too much discipline circulate within public discourse. De Benedictis (2012) argues that prevailing neo-liberal ideology promotes 'stricter forms of parent subjects' and, consequently, 'stricter formulations of the 'good father' (2012:6). Parents are held responsible for their 'out of control children' and their parenting is considered to be lacking in moral authority. For many commentators, children with an ADHD diagnosis fall into the category of 'out of control' children. The subject position of disciplining father has a rhetorical expediency that is drawn upon to construct fathers as having moral authority and to resist their positioning as ineffective parent.

It is interesting, but perhaps not surprising, that less traditional subject positions such as the 'new father' were not, except on a few occasions, taken up. Arguably, the new father subject position does not have rhetorical expediency when explaining to an interviewer the experiences of *parenting* (not *fathering*) an ADHD child.

This section has also noted how the subject positions of 'out at work father' and 'stay at home' mother are made relevant in fathers' (and mothers') accounts of their parenting. These two subject positions are also made relevant to establish

the respective domains of expertise of mothers and fathers, which is the focus of the next section.

8.4 Constructing domains of expertise

The following extract is from the interview with Jane and Alan. They are discussing how having a child with ADHD impacts on their parenting strategies.

The 'out at work' but 'hapless' father

Extract 7, Alan and Jane

Jane: *and I hear her saying 'oh you're so lucky that both ...you know that Alan is like really supportive and you're both' ...and the lady said 'I really don't need to see either of you on your own' [...] and both of us sharing the load uhm*

Alan: *you have more of the load than I do 'cos I work so ...*

Jane: *well yeah but it's [...]*

Alan: *but then you're helping me learn the right language 'cos sometimes I use the wrong language I use uhm language that doesn't... probably inflames but it's getting the right language to not to try and get it on the right path where if I'm at work all the time or most of the time I haven't... sunk in...*

Jane: *yeah people do as they're told at work but they don't at home do they as such?*

At the beginning of this extract, Jane repeatedly uses the word **both** which works to build an account of their successful joint parenting and suggests a mutually equal and supportive parenting team. However, even within this construction of a parenting team, Alan's role is rhetorically positioned in relation to Jane's. Jane begins to report one professional's opinion of their parenting '**oh you're so lucky that both ...**' but then stops and repairs this statement with '**you know that Alan is like really supportive**'. Jane shifts the focus from a quality that both of them share to one that Alan has. Significantly, in singling out Alan's supportive role as a

category worthy of account, her own 'non-categorised' role becomes the taken-for-granted, normatively shared 'backdrop' (Edwards, 1994; Edwards, 1991) that requires Alan's support. Alan's positioning as a father who provides support could be interpreted in two, paradoxical, ways; firstly, that Jane requires support because she is somehow in a vulnerable, 'weak' position, and is in need of emotional support, or alternatively, that she is in the 'controlling' position and requires practical support to do her job effectively. These meanings clearly make available very different, but very gendered subject positions for Alan. The former interpretation positions Alan as the emotionally stoical, 'sturdy oak' of Pleck's study (1987). The second interpretation suggests a subordinate role that is somehow monitored and regulated by his wife (Arcidiacono and Pontecorvo, 2010; Featherstone, 2009). Alan's immediate reply that his wife has ***more of the load than*** he does, and his subsequent remark that Jane is helping him ***learn the right language*** suggests that he is orienting to the second interpretation; that of a 'subordinate' parent. Alan's responses to his child are defined by Jane. This resonates with Doucet's suggestion (2006) that fathers rely on mothers to define their fathering, and that mothers take on, what Featherstone (2009) identifies as, a maternal gatekeeping role. That is, mothers mediate men's parenting and play a critical role in interpreting their children's behaviour for their partners.

As with extracts 3 and 4, the gendered subject position of working father is made relevant. In this context, however, it is used to provide justification and accountability for why Alan does not share so much of the load ***you have more of the load than I do 'cos I work***, and also for why he is not so skilled at managing his child ***I use the wrong language I use uhm language that doesn't ...probably inflames [...] I'm at work all the time or most of the time I haven't***

... Alan's account of himself as a father who inflames the situation at home, partly because he spends so much time at work, is potentially troubling. Indeed, Alan

orients to this possible trouble by softening his extreme case formulation ***I'm at work all the time or most of the time.***

This extract is typical of how fathers are positioned, and position themselves, as the less 'knowing', somewhat hapless parent at home. This is interesting as it is a, potentially, troubling position to occupy, with so much critical judgement directed towards parents of children with ADHD. However, the deficient father is rhetorically constructed by making relevant other 'good father' positions; such as the 'out at work' father and the 'emotionally strong' or 'supportive' father. The 'hapless' father subject position also creates a discursive space for mothers to occupy as the 'good mother', another gendered subject position. As Doucet (2006) suggests, the 'symbolic power of mothering' is such that women are reluctant to give up this area of power and expertise and, consequently, fathers are, at times, excluded from taking on the care and emotional responsibility of their children. Similarly, Lupton and Barclay (1997:132) suggest, 'men's subject position as a 'good' father appears not to depend to quite the same extent upon demonstrating expertise in and dedication to the care of one's children'. In this data set, fathers are rarely critical of the way mothers manage the children, and, indeed, are keen to praise their wives' handling of their children. This contrasts with the mothers who were often (gently or ironically) critical of their partners' (ex- partners') management of their children. Arguably, both fathers and mothers collude in the protection of certain gendered subject positions because their identities as 'good father' and 'good mother' are indexically bound up with maintaining these positions.

Fathers are able to risk taking up the 'hapless' father subject position, as they have alternative subject positions they can occupy which serve to mitigate their deficiency at home. The 'out at work' father subject position is a culturally shared representation of responsible masculinity (certainly with regard to current political

discourse) and, thus, carries moral authority, a quality that parents of children with an ADHD diagnosis are particularly invested in displaying.

The subject positions of 'disciplining' father, 'emotionally strong' father and 'out at work' father are drawn upon to do moral work, and to counter alternative versions of fathering made available through the psychosocial repertoire of ADHD, and, indeed, wider discourses of irresponsible parenting. The medical/biological repertoire makes available very different subject positions. It makes available the subject position of expert parent. Engaging with the medical repertoire of ADHD, makes available a specialised type of expertise for parents to lay claim to, and this is made a very relevant concern by the parents in this study. However, the construction of expertise performs different work for the mothers and fathers, some of which, again, is aligned with gendered subject positions.

Domains of expert knowledge

The take up of the medical model by mothers is well-documented (see Chapter 3). Engagement with the medical model provides resistance to the subject position of inadequate parent, and also makes available the subject position of parent as expert (of their children's medical condition). A medical framework creates a discursive space for non-professional expertise (Shaw, 2002) as it permits non-professionals to draw on their own experience of whichever medical condition is framed. However, despite this, fathers' take-up of the medical repertoire is much less documented and, furthermore, Singh (2003) suggests that fathers are sceptical of ADHD as a diagnosis and show resistance to understanding their children's behaviour within a medical framework. Although in this study, fathers draw on the biological/medical repertoire to construct their explanations of ADHD, their engagement with the medical model is more troubled than the mothers' engagement with it typically is.

The following extracts demonstrate how expertise becomes a participants' concern within these interactions, and how the construction of expertise about ADHD can perform different work in different domains; from positioning fathers as 'less' expert than their partners at home, to positioning them as knowledgeable fathers about their children's condition within institutions such as school. Extracts 13 and 14 examine how fathers legitimise their knowledge claims through their own experiences, and how this experiential knowledge is deployed to challenge aspects of medical authority.

The confused father

In this extract, Caroline is talking about her husband's understanding and approach to their son's ADHD.

Extract 8, Caroline

Caroline: *uhm...it's... we've been on the same page I don't think there's been any point we've been uhm er that's been you know I haven't... he's always accepted that there are difficulties my husband we haven't had the problem that I know a lot of families have where ...*

Alison: *mmm*

Caroline: *dad's not involved*

Alison: *mmm*

Caroline: *and he's just saying 'oh boys will be boys' or you know...we haven't had any of that he's been very much on board from the beginning I think we worked very well uhm because what we... he supported me and I supported the children and I think we went down that... and it had to work that way and we just held on as best we could through the worst storms*

Alison: *yes yes*

Caroline: *and we did it together but the genuine real understanding was me I was the one
but then that's often the case*

Alison: *yes it is*

Caroline: *he didn't really get it he's never really got it*

Alison: *no*

Caroline: *I mean he still doesn't [...] I kind of make the rules in a way 'right ok this is what
we're going to do'*

Alison: *(laughs)*

Caroline: *'and these are the new rules and this is how the boundaries are going to work'
not for my husband actually (laughs)*

At the beginning of this extract, Caroline problematizes the role of fathers in general. She says fathers constitute **a problem that I know a lot of families have where [...] dad's not involved [...] and he's just saying 'oh boys will be boys'**. This description of other families, specifically, other fathers, is rhetorically designed to imply that this type of attitude is typical and routine. Through the use of extreme case formulation **a lot of families** (Pomerantz, 1986) and the unmodified present simple tense to establish routine **have, is not involved**, Caroline formulates a script of other fathers that establishes the normative base against which her own husband's actions can be judged (see Edwards, 1994), and praised. His stance in relation to ADHD, can be 'praised' as it is not as 'ignorant' as other fathers'. In setting up her husband's stance indexically with the stance of other fathers, then the arguments Caroline suggests are put forward by the other fathers '**oh boys will be boys**' are implicitly criticised, and, thus, undermined.

The phrase 'boys will be boys' works to normalise the behaviours associated with ADHD and is usually used to undermine parental decisions to pursue medical diagnosis by people sceptical of the medicalization route. Caroline's use of the

phrase here constructs such sceptics as lacking in real understanding and serves to solidify her (and her husband's) medical interpretation of their son's behaviour.

Although Caroline's husband is compared favourably with other fathers, his understanding of ADHD is positioned as contingent. She says that her husband has ***always accepted that there are difficulties***. The use of 'accepted' suggests her husband holds an attitude towards a matter which is contentious, if not controversial (Billig, 1996). It suggests a choice. Similarly, she says ***he's been very much on board from the beginning***, which, again, suggests an 'agreement' with an issue or approach. The implication here is that her husband's engagement with her son's ADHD is one that he has chosen to take-up, but that this engagement (and perhaps that of all fathers) is not one that cannot be assumed or taken for granted. Through her talk, the father's engagement is constructed as contingent and agentic, whereas her engagement with her child's ADHD is taken-for-granted (she is already on board). The father here is positioned outside of the mother-child relationship he ***supported me and I supported the children***. In this section, Caroline orients to traditional notions of fathering and mothering; that a stable and reliable paternal presence assists, and even enables, the maternal caregiving role (see Bowlby, 2005; Winnicott, 1984).

Similarly powerful gendered subject positions are made relevant by Caroline towards the end of this extract. Having established her husband's contingent engagement with her son's ADHD, and rhetorically positioned it favourably vis-à-vis the stance of other fathers, she then works up a construction of him as not really understanding ADHD: ***he didn't really get it he's never really got it***. His knowledge is indexed against her own ***genuine real understanding*** of her child's condition. This resonates with existing literature that suggests that mothers position themselves (and are positioned) as the partner who has a better

understanding of their children's needs (Doucet, 2006; Lupton and Barclay, 1997). In addition, Caroline's **real understanding** provides a justification for Caroline's positioning of herself as the parent that drives the management of their son **I kind of make the rules**. This makes relevant the very gendered position of mother as main caregiver and the parent who assumes responsibility for their children, in general, and specifically, in matters of health (Seymour-Smith and Wetherell, 2006; O' Brien, 2005).

In this extract, fathers' understanding of, and engagement with, ADHD is problematized within the family, both generally (other families), and specifically (in this family). This creates a space for the mother to assume the position of expert and to assume some kind of social control (Seymour-Smith and Wetherell, 2006) in relation to their child. However, at the same time it reinforces quite traditional gendered subject positions within the family.

The following extract resonates with Extracts 7 and 8 in terms of positioning the father as deficient in comparison to the mother's engagement with matters concerning their child. Gill describes how she reads the information about ADHD and then only shares what is relevant with Mick.

Fathers' contingent knowledge

Extract 9, Gill and Mick

Gill: *yeah I only found out reading a couple of books written by parents and joint with parents and psychologists about ADHD and top tips on how to get the best from your child at school uhm so I had to look at all of that to uhm s... not waste time*

Alison: *so you you so it's all it kind of seems a lot of this is your own research isn't it? you're doing a lot of work to ...*

Gill: *oh yeah yeah quite a lot I've been through lots of information and then I just filtered what was interesting or relevant or different strategies for M (laughs)*

Mick: *(laughs)*

Alison: *(laughs)*

Gill: *cos I knew he wasn't going to read all these books actually he read one*

Gill's construction of herself as a 'good' mother is accomplished through her account of her dedication to researching around her son's ADHD. The extent of her dedication is emphasised through use of extreme case formulations (Pomerantz, 1986) *I've been through lots of information* and later, *all these books*. Her knowledge and expertise is constructed as indexical to Mick's; he has read one book and his knowledge regarding ADHD has been filtered down by Gill. Gill positions herself as the 'expert' on ADHD within that household; Mick's knowledge (and expertise) is, thus, contingent on Gill passing on information. It is regulated and on a strictly needs to know basis.

Gill's indexical construction of herself as the informed and interested, expert mother, could imply that Mick is an uninterested father; a risky subject position to be made relevant. The potential for trouble is resisted through the use of laughter and the use of the word 'just' in Gill's statement *I just filtered what was interesting or relevant or different strategies for M*. The use of the word 'just' serves to normalise this filtering of knowledge; it is a mundane and ordinary activity. In normalising this activity, Gill appeals to a commonly shared understanding of how mothers and fathers manage knowledge about their children within the family. By invoking a general practice, she is working to counter any suggestion that her and Mick's practices are exceptional or wrong.

The examples we have seen so far position the mother as holding a better knowledge of their ADHD child within the family context. The confused or ignorant

father is a potentially troubling position to take up as much public discussion about ADHD centres around issues of misdiagnosis and parents rushing to diagnosis as a way of absolving themselves of parental responsibility. To counter such interpretations, fathers claim alternative domains of expertise in contexts outside the family as shown in the next two extracts.

The expert father

Extract 10 comes from the interview with Alan and Jane, and Extract 11 comes from Martin's interview. In both extracts, the fathers are explaining how they took information regarding ADHD to their sons' schools.

Extract 10, Alan

Alan: *I took in books that we'd obviously bought and say 'do you want to read them? That might help you.'*

Extract 11, Michael

Michael: *I provided some textbooks I mean it's not to say that the school would have no knowledge but I just thought whatever knowledge they had it would be useful to provide some textbooks to help them so these were books about teaching so they were more for people in the classroom*

As with the examples above, several of the fathers talked about physically handing over or taking in books to help teachers. Knowledge is quite literally, transferred from one site (the family) to another (the school). As Billig *et al.* (1988) suggest, it is the possession of knowledge which confers expertise; in these instances, possession is represented physically through the books. The handing over of knowledge to teachers not only represents fathers as knowledgeable about ADHD but confers a professional authority.

The take up of the expert and knowledgeable father in this context serves as a rhetorical rejoinder to the position of the 'hapless', ignorant father that is taken up at home. However, the somewhat contradictory positioning of fathers as, ignorant in one context (about their children and ADHD), and knowledgeable in another suggests an ideological dilemma (Billig *et al.*, 1988). An ideological dilemma evidences the 'inconsistency, fragmentation and contradiction' of lived ideologies apparent in common sense understandings of the social world (see Edley, 2001a). Within this data set, fathers are positioned as both knowing and not knowing about their children, signalling contradictory ideas of what it means to be a (good) father. Differing accounts of fathers' knowledge demonstrate how fathers (and mothers) undertake rhetorical work to 'make sense' of these contradictory ideas.

Consistency is established, however, across both contexts, as being a good father is the 'interpretative scaffold' (Terry, 2010:77) upon which fathers construct their accounts. The fathers deploy various cultural resources to talk about their experiences of being a father of an ADHD child, which, although contradictory, permit the 'carrying' across contexts of their identity as a good father. As Terry (2010) and Redman (2001) argue, social identities are highly relational and struggled over, 'involving intricate assertions of likeness to and difference from key social others' (Redman, 2001:189). This is clearly significant with regard to highly gendered notions of good mothering and good fathering. The ideological dilemma evidenced by the contradictory subject positions of 'ignorant' and knowledgeable father points to an ideology that permits gendered differences in approaches to responsibility for children. Fathers are able to relinquish being the 'expert' parent at home, because culturally, and historically, ideology permits, even encourages, the responsibility for care of children to fall to the mother. However, ideology is also infused with themes which promote the active involvement of fathers in family life (Robb, 2004a) and the nurturing role of fathers (Lupton and Barclay, 1997).

Fathers, therefore, also need to account for themselves as caring and involved without threatening the position of the 'good mother'. As Doucet argues (2006), fathers work to distinguish their caring from mothering and construct a particular kind of masculine care that retains some relationship to traditionally valued masculinity. The expert father who passes on their knowledge to schools is one way in which this is seemingly accomplished, resonating also with Doucet's (2006) discussion of borderwork, in which she says that parents' gendered positioning as moral beings takes place within defined spaces and times. Fathers' responsibility for their children is conveyed through community involvement, which builds on traditional male interests and connections. Arguably, schools provide a 'professional' space (not all school spaces, and not all times) for fathers to demonstrate their moral responsibility for their children.

These accounts of gendered differentiated parenting also echo Lupton and Barclay's findings (1997), that notions of the good father included displaying expertise learned from reading appropriate material. The following extract provides another example of how knowledge, and, specifically, fathers' *pursuit* of knowledge, or 'the truth' is also deployed as a resource in the construction of good fathers. It also provides further evidence of the ideological dilemma outlined above.

The interested father

This extract comes from the interview with Gill and Mick, and comes just after extract 9, where Gill accounts for how knowledge and expertise about ADHD are managed at home.

Extract 12, Mick

Mick: *and just reading stuff about ...well it wasn't necessarily about ADHD just to understand different psychologies ...that it isn't just a hocus pocus bullshit science [...] Oppositional Defiant Disorder and just reading through that it ...the treatments and the scenarios are similar and it made me understand him a lot more*

According to Gill's version, it is Gill that reads about ADHD and then she passes on to Mick whatever she feels is relevant. According to Gill (in Extract 9), Mick has only read one book. Mick's claim that he had been **reading stuff [...] about ADHD** **is** ambiguous in relation to how many books he has actually read. It is interesting to note that, even if Gill has read more books on the subject of ADHD than Mick (which is the implication in her account), Mick's reading here is constructed as being purposeful. He is reading so that he can put his 'seal of approval' on the science behind explanations of ADHD. There is also the sense that it was through Mick's own reading that he came to a better understanding of his son **it made me understand him a lot more**. There is no sense that this understanding is contingent on Gill passing on information that she had read. As discussed above, the shifting versions of Mick's pursuit of knowledge suggests that different work is being done on each occasion. In Extract 9, Gill is taking up the position of expert, and good mother, and indexically constructing herself in relation to Mick. The focus in that extract is on showing how knowledge regarding their son is jointly managed. In Extract 12, Mick is taking up the position of good father; constructing himself as well-informed and interested in his child's welfare. In this case, the pursuit of knowledge is deployed as a 'tool of empathy' (Rafalovich, 2008:160). Mick resists a possible judgement that he may have rushed into a diagnosis of ADHD, a commonly and prevalent assumption of parents of children with ADHD. He does this through the use of stake inoculation (Potter, 1996). Contrary to what

might have been expected, by reading about ADHD and other medical classifications, Mick shows how he was not 'duped' into an inaccurate diagnosis. He suggests an initial willingness to be sceptical of the 'psychology' around ADHD; he needed to be reassured that it *isn't just a hocus pocus bullshit science*, which, again, resonates with the discursive pattern 'at first I thought, but then I realised...' (see Chapter 4). Mick's typical rational and neutral stance is disrupted by unusual, but empirical and scientific, evidence obtained from the reading he has done. The knowledge Mick has gained from reading these books is constructed as true through the use of the truth will out device (Potter and Wetherell, 1987; Gilbert and Mulkay, 1984); the psychological knowledge has given Mick a better understanding of his son *it made me understand him a lot more* and so, the science must be true.

Mick's use of the quite strong expression *hocus pocus bullshit science* invokes a willingness in Mick to be defiant and resistant to medical authority. Although all the fathers engage with, and deploy, the medical repertoire of ADHD, they also all demonstrate a certain resistance to particular aspects of it. This resonates with Hansen and Hansen's (2006) and Singh's findings (2003) that fathers are far more sceptical of the medical model, identifying them as either 'reluctant believers' or 'tolerant non-believers' (Singh, 2003). The sceptical, resistant and, even, rebellious father subject positions are made relevant by all the fathers in this study. These positions are legitimised through the invocation of fathers' own experiential knowledge.

8.5 Resisting the medical narrative

The following extract comes from the second focus group in which the conversation has just turned to medication.

The rebellious father

Extract 13, Mick, Alan, Jane, Gill

Alan: *I took J's medication and uhm I could actually ...*

Mick: *was that the day he forgot?*

Alan: *no, no (laughter) no I just... I'm giving this to my son what am I giving him? So I took it and I could actually feel my brain slow down*

Alison: *really?*

Alan: *I could actually feel...*

Jane: *cos you are quite impulsive sometimes if we're sitting [long anecdote about how Alan can't sit down for long] [...]*

Alan: *it was interesting to feel my brain slow it wasn't ...*

Mick: *in a positive way or sort of a (makes zombie like noise)?*

Alan: *uhm was it positive? Uhm*

Jane: *well I think it helped you rationalise it ... the tasks*

Alan: *yes I could go... cos it was like the garden needs uhm hoovering uhm mowing and I'll be up go and do it ok the garden needs doing but I don't need to do it now it gave me enough time to go 'I don't need to do it' where if I didn't ...*

Here Alan describes how he took his son's medication to really 'know' what it is that he is giving him: ***I just...I'm giving this to my son what am I giving him?***

So I took it... The use of the minimising adverb 'just' and the transition signal 'so' contribute to an understanding that Alan's action is routine and 'nothing special'.

This works to resist a 'heroic' interpretation of Alan's actions. Alan's action is formulated as an instance of a general pattern of expected behaviour (see Edwards, 1994 for a discussion of script formulation). Alan is 'doing being ordinary' (Holstein and Gubrium, 2000; Sacks, 1995). By presenting himself as a non-

exceptional father, his membership of that group remains intact. He was simply doing what any ordinary and 'good' father would do under the circumstances. In testing the medication for his son, Alan takes up the position of responsible father, resisting the position of the irresponsible, unscrupulous parent made available by the psychosocial repertoire (see Goldberg, 2011; Horton-Salway, 2011). In addition to positioning him as a good father, Alan's admission that he has taken his son's medication also contributes to a distinct entitlement to knowledge. Alan's entitlement to make claims and choices about medication for his son is warranted by his experiential knowledge of the drug. Alan can now claim with authority that the drug does what it supposedly should do ***I could actually feel my brain slow down.***

Alan's report of taking his son's medication also works to expose the fragility of medical authority, and positions Alan as, potentially, resistant to it. He is, quite reasonably as an ordinary father, questioning what he is being told to give his son. Further resistance to medical authority comes from Alan's ambiguous response about whether the experience of his brain slowing down is a positive one or not. He describes the experience as ***interesting***, but when asked if it was positive, does not, initially, commit to a definite verdict ***uhm was it positive? Uhm...*** A description of the benefits of the medication is prompted by Alan's wife, Jane ***well I think it helped you rationalise it...the tasks*** after which Alan describes how the medication helped him prioritise tasks. Alan's resistance to the medical narrative somewhat supports Singh's (2003) consideration that within families there is a potential tension between a father's authority and medical authority.

Medication is the subject of the next extract taken from Gill and Mick's interview. In this extract, Gill and Mick are discussing their son's probable future need for medicalization. This extended extract is provided as an example of how fathers

and mothers work up different knowledge entitlements regarding ADHD and so, initially at least, take up different positions regarding medication, as suggested by previous research (Singh, 2003).

The reluctant father

Extract 14, Gill and Mick

Mick: *also I I I don't want to see his personality change too much [...] I think most parents would say that... well maybe (laughs) I don't know*

Gill: *yeah but I [I don't think]...*

Mick: *['cos if he's (unclear) [his personality won't change] but*

Gill: *it won't*

Mick: *but he's but he's a er a very excitable very enthusiastic boy and you know that's great about him you know I wouldn't want...*

Gill: *but it won't dampen down...I've been reading a lot about the types of medication it won't turn him into a zombie it won't Mick because how would he be able to function at school? The medication is to get the best out of him in terms of his learning ability [...] it actually makes his br...you know ... think...focus he'll be focused he'll be able to retain information [...] it means 100% it will impact on his ability to learn*

Mick: *yeah but when you're trying to get the right dose surely then you're trying to get the right dose and the right drug because you want the right side effects and surely if you're not getting the right one the wrong ones are adverse effects?*

Gill: *no the side effects will be ...well the side effects they start on the lowest dose because it's linked to body weight*

Mick: *ok*

Gill: so he'll start on an absolute minimum dose and tweak it up they don't give you a massive dose and work (laughs) their way back down that's not how psychiatrists medicate... they err on the side of caution they'll give that lowest dose and tweak and tweak and tweak until they find the right balance of ...

Mick: see for for myself I I mean I'd be interested because for myself uhm I'm when I'm working there can be a million and one things (unclear)[0:54:44.3] well not a million but you know lots and lots of things going on in my mind and I I had to train myself to concentrate on 'do this' or 'do that' I have to pfff (whistling sound) you know back to the main task and is it it's it's a what-do-you-call it? a discipline you know and I've had to learn it [...]

Alison: you've had to learn it

Mick: and and it has...it almost takes over my life in a way because I do things in a strict order ugh ugh not a strict order but I try and do things in an efficient way to ...'cos I know that I've got all these things to do I can't just leave them all and concentrate on one they're all going but they have to be done in the right order [...] I I sometimes work on four computers at once uhm and I always have done [...] but I've always got to discipline my mind to focus on what's important you know whereas...

Gill: but you quite like that and because you're a lot older than J now [you've disciplined yourself]...

Mick: [yeah but without that discipline] I'd be a scatterbrain

Gill: ...for years and years and years so you know you can (unclear)[0:55:48.8] computers your brain duh-duh-duh-duh you can cope with that 'cos that's how you've worked and so I guess you're thinking oh God if J can't do that anymore

...

Mick: *yeah if he can't [discipline that]...*

Gill: *[he'll be] and you feel that's sad because if you took that medication and you're only able to concentrate on ...*

Mick: *no no no no no no no I I I would...if I took if I had that medication I would be able to concentrate I would probably benefit from it because I'd be able to concentrate on one thing at once but as it is I have to discipline myself to concentrate [...][and I have to keep things ticking over in the back of my mind about whether things...and then I can switch concentrate on that ok I can't go anywhere else with that I've got it into there now der der der 'cos that's doing der der der and they're there and back there ok right I can concentrate to do it but all ...there's loads of stuff going on in the back of my mind whereas if that's what's happening to Ja and he's not able to discipline himself then it's still 'oh what's going on? I'm playing X box tonight' and der der der der der and there's no discipline and then and then you maybe you need the drugs to ...*

Alison: *to help with the discipline*

Gill: *yeah*

Mick: *but that's just something to learn you see not not you know not drug induced*

Mick's primary concern in this extract is that his son's personality might be changed through medication ***I don't want to see his personality change too much*** and later ***he's a er a very excitable very enthusiastic boy and you know that's great about him you know I wouldn't want...*** Although Mick does not explicitly express a rejection of pursuing the medical route, he *implicitly* expresses his ambivalence towards it, a stance identified in several studies (Hansen and Hansen, 2006; Bussing and Gary, 2001). Resistance to a medical interpretation of his son's behaviour is suggested by the way that Mick normalises his son's behaviour through the use of the adjectives excitable and enthusiastic, which work

as script formulations (Edwards, 1994) of normal boyhood. On this particular occasion, Mick clearly establishes that his son's behaviour is not so problematic (for him, at least) as to warrant medication. This has similarities to Singh's (2003) findings that the majority of fathers in her study did not believe that their sons' behaviour warranted medical attention and that explanations of their son's behaviours could be found in the maxim 'boys will be boys'. Although Mick does not explicitly say what he fears medication will do to his son, he does not contradict Gill's interpretation that he fears his son's personality will be **dampen(ed) down** or that he will be turned into a **zombie**. The psychosocial repertoire makes relevant the subject position of amoral, and even abusive, parent who is too quick and too willing to medicate (Horton-Salway, 2011). Clearly, Mick's concern about the effect of medication resists such positioning.

However, resisting the medication route can also be a risky position for Mick to take up. Acceptance of medication as a way of managing ADHD is integral to the medical repertoire, which, as has been discussed, absolves parents of responsibility for their children's unruly behaviour. In resisting medication, parents become morally implicated in, and responsible for, managing their children's behaviour, which may account for Mick's somewhat ambiguous and implicit resistance. Mick's description of his son's behaviour as excitable and enthusiastic, as well as normalising his son's behaviour as typical of all boys, performs alternative work, especially when prefaced with the modifier 'very'. These adjectives could also 'point to' a presupposed underlying pattern of behaviour associated with ADHD as a medical category. It is interesting that Mick chooses these adjectives, rather than say, 'engaged' or 'interested', which, arguably, are more neutral descriptors of similar behaviour. By using the words excitable and enthusiastic, Mick is hinting at the underlying pattern of ADHD, while also managing to suggest that these behaviours are not pathological. This use of the

documentary method of interpretation (Garfinkel, 1984) therefore allows Mick to adopt an ambivalent position towards medication, a position which can shift depending on the demands of the context.

Claiming epistemological warrant

Mick's entitlement to raise doubts about the use of medication is grounded, partly, in experiential knowledge. As with Singh's study (2003), the fathers in this study identify with their sons' behaviours. Through the use of extreme case formulation and script formulation, Mick scripts his own 'hyperactive' behaviour as typical and routine for him ***when I'm working there can be a million and one things well not a million but you know lots and lots of things going on in my mind and I sometimes work on four computers at once [...] I always do that [...] I sometimes I shoot on a chair on wheels whizz across the room to have a look...*** As with the use of the documentary method of interpretation (Garfinkel, 1984) discussed earlier, these descriptions serve two functions. Firstly, they work to normalise, or at least, resist the pathologisation of Mick's own, and his son's, behaviour. After all, Mick's behaviour has its virtues, and allows him to multi-task, as in the examples above. Mick also describes how he has managed to control the negative effects of these behaviours through self-discipline, rather than through medication.

I I had to train myself to concentrate on 'do this' or 'do that' I have to [...] it's a what-do-you-call it? A discipline you know and I've had to learn it and later he says ***I've always got to discipline my mind to focus on what's important you know whereas...***

Secondly, however, Mick's vivid description of his own behaviour also works to document the symptomatic patterns underlying an ADHD diagnosis and so suggests an identification with his son's medically classified behaviour. Although

he works up an entitlement to knowledge and opinion based on his personal experience of having ADHD-type behaviours, Mick holds back from actually directly claiming the ADHD label for himself, instead suggesting that, without discipline he would be a bit of a **scatterbrain**. The topic of concern in this extract is the potentially fraught one of medication. The dilemma facing Mick and Gill is whether to medicate or not. So, despite identifying with his son's behaviours, there is, arguably, the need to also distance himself from them too. After all, Mick has managed his own behaviours through self-discipline. If he claims the category of ADHD, then the (and his) arguments *against* medication would be much stronger, and might risk a more serious confrontation with Gill, who, on this occasion has expressed very clear support for medication. The moral dilemma facing Mick is conveyed through his somewhat contradictory statements towards the end of the extract ***if I took if I had that medication I would be able to concentrate I would probably benefit from it because I'd be able to concentrate on one thing at once but as it is I have to discipline myself to concentrate*** and then later ***but that's just something to learn you see not not you know not drug induced***.

In these quotes, Mick draws on both the medical and the psychosocial repertoires. He acknowledges the possible benefits of medication and how it might have helped him concentrate, but he also orients to the psychosocial argument that aligns ADHD behaviour with (self) discipline. Interestingly, his construction of self-discipline is ambivalent. It requires a lot of work and time ***it almost takes over my life in a way***. His ambivalent construction of self-discipline permits him to hold both positions on medication. In, partially, aligning himself with the view that troubling behaviours can be controlled through self-discipline, he positions himself as a responsible father who both acknowledges the value of discipline and who does not rush to medicate their son. However, in constructing self-discipline as all-consuming and extremely hard work (even for someone like him, who does not

claim the label ADHD), he makes it possible for himself to take up the option of medicating his son, in his son's best interests.

Unlike Mick, Gill presents a very systemised, non-problematic and, arguably, idealised version of medication. Gill's description of her engagement with the medical model is very different from the one espoused by Mick and Alan. Her account of medication is constructed as true through use of 'will' and present simple tenses to convey a certain, factual future (rather than modals or adverbs of likelihood which convey a far less certain future), for example, ***it won't turn him into a zombie it won't Mick and it actually makes his br...you know...think...focus he'll be focused he'll be able to retain information which means [...] the side effects will be...*** This absence of modality (see Woolgar, 1988) constructs the effects of medication as predictable, routine and, crucially, unproblematic. Gill's claims are strengthened by her use of extreme case formulation ***it means 100% it will impact on his ability to learn.***

Most significantly though, Gill aligns herself very closely with the medical and education experts in her account of the benefits of medication. ***I've been reading a lot about the types of medication it won't turn him into a zombie and they don't give you a massive dose and work (laughs) their way back down that's not how psychiatrists medicate.*** In these examples Gill is working up her entitlement to make certain knowledge claims. Her entitlement to epistemological warrant (see, for example, Sacks, 1995) is derived from the knowledge she shares with experts. In this extract, Mick's doubts and concerns about medication are rhetorically positioned against expertise and, thus, undermined. In particular, the use of laughter in the last quote works to construct Mick's concerns as naïve, foolish and deviant from the normative approach to medication (see Horton-

Salway, 2004; Jefferson, 1984 on the use of laughter as a departure from the norm).

This section of the chapter has highlighted how fathers and mothers work up different entitlements to knowledge within different contexts to perform different work. Establishing the legitimacy of knowledge and domains of expertise permits fathers (and mothers) to take up subject positions which establish distinct, but, crucially, moral identities.

Mick's identification with his son's ADHD behaviours is typical of the fathers in this study. Supporting Singh's findings (Singh, 2003), all the fathers in this study identify, in some ways, with their son's ADHD behaviour. However, equally, they work to distance themselves from this behaviour too. The following section explores how fathers identify with their son's ADHD, and how they manage their own potential ADHD identities.

8.6 Fathers' identification with ADHD

The following extended extract comes from the interview with Jane and Alan. They are discussing the genetic basis of ADHD.

Categorisation and particularisation of the category ADHD: The hyperactive father

Extract 15, Jane and Alan

Alison: *do you uhm if someone was to ask uhm ask you to account for where it comes from do you account for it in anyway? (Jane points at Alan) (all laugh)*

Jane: *genetics*

Alan: *genetics yeah my dad's near enough identical to J in terms of ADHD and Asberger's uhm probably a bit more high functioning than Jane uhm*

Jane: *behavioural traits are exactly the same*

Alan: *yeah*

Jane: *he's not ac...he's at well they were here when we were at the wedding he's
unable to let anything go*

Alan: *yeah yeah*

Jane: *so he would rather disrupt everything that's going on to get his own way than
walk away even as an adult*

Alan: *yeah*

Jane: *and I think that's something we would like to...or we pick up quite a few
negatives from him we actually want to change for our own son to ...*

Alan: *yeah*

Jane: *so that when he does get to that point we want to you know ...my mother-in-
law was saying 'oh yes you know he had had you know quite a lot of
interference' and uhm I know what she means because he doesn't like what's
going on and rather than taking himself out of the situation*

Alan: *yeah he won't*

Jane: *and have some peace and quiet that he wants he'll need to keep on disrupting
and disrupting and disrupting until*

Alan: *he gets his own way*

Jane: *his own way*

Alan: *so then you've got...so we try and limit our exposure to him 'cos two controlling
personalities let alone my personality in the mix as well 'cos I've got a bit of the
hyperactivity aspects but I don't think I've got any of the other [...]*

Jane: *and I don't think it never crossed my mind about ADHD then until until we'd had
...*

Alan: *well I'd always said he was socially inept*

Jane: *well yeah*

Alan: *because my dad could was just difficult to deal with and then when he talked about ...*

Jane: *cringing*

Alan: *his work*

Jane: *it was cringeworthy it was everything you wouldn't want to mix him with people that you knew because [...]*

Jane: *I truly believe it comes through but I think some things get diluted and other things come out and I guess it depends on you know other factors like your family*

Alan: *but it's the male gene though isn't it? 'cos it (unclear) [0:48:40.2] my line is very male*

Jane: *yes yes much rarer in female [...]*

This extract is particularly interesting because Alan's identification with his own son's behaviour is embedded within an account that also constructs similarity between Alan's father and Alan's son. However, despite partial identification with his son, Alan works to distance himself from his father.

In the first part of this section, Alan and Jane jointly construct Alan's father as an adult who displays **exactly the same** behavioural traits as their son. Alan's father's behaviour is scripted (Edwards, 1994) through the use of verbs typically used to denote disposition (underlined in these examples) **he's unable to let anything go** and **he would rather disrupt everything that's going on** and **he'll need to keep on disrupting and disrupting and disrupting**. In line with the documentary method of interpretation (Garfinkel, 1984), these behaviours not only provide evidence of his having ADHD, but also elaborate the meaning of ADHD.

The similarity between grandfather and grandson is described in response to a question about the origin of ADHD, and it provides evidence to support Alan and Jane's claim that there is a genetic predisposition to ADHD. Jane and Alan's description of Alan's father is a highly critical one, and, this, clearly, has implications for the way their own feelings towards their son might be perceived. A crucial difference between grandfather and grandson is intimated (by Jane especially) by drawing on the complexity of understandings around ADHD. In particular, Jane, and Alan make relevant issues of responsibility and (taught) self-control. In describing Alan's father's lack of ability to walk away from a situation, Jane adds ***even as an adult***. There is a sense here that as an adult, he should have more control over his behaviour; behaviour that may be acceptable in a child is unacceptable in an adult. This somewhat contradicts Jane and Alan's position elsewhere in the interview when they align ADHD with a lack of (ability to) control or self-regulate. Similarly, Jane then indicates that there are certain negative behaviours that her son shares with his grandfather that she and Alan ***want to change for our own son***. ADHD and its symptomatic behaviours are constructed here as not fixed, but manageable and possible to control. Again, it is a different representation of the condition than expressed in other places in the interview. Jane and Alan manage to negotiate a distance between the grandfather and the grandson by drawing on self-control and (their) good parental guidance as 'benign' influences.

The problematic behaviour is invoked through descriptors such as ***he was socially inept*** and ***just difficult to deal with*** and ***cringeworthy***. Whilst these instances of behaviour serve as documentary evidence of ADHD, they are also problematic. As outlined above, the description of Alan's father is provided as evidence of the genetic bias of ADHD. However, suggesting such problematic behaviours have a genetic basis, has serious implications for how Alan and his

son are represented. The complexity of ADHD is worked up by Jane and Alan to permit a distancing of both their son, and Alan, from the grandfather, whose behaviour is so clearly problematic to them. Aspects of both the biological and psychosocial repertoires are drawn upon by Jane, in particular, to construct her account of ADHD ***I truly believe it comes through but I think some things get diluted and other things come out and I guess it depends on you know other factors like your family.*** Jane and Alan's genetic account for ADHD still stands; however, Jane provides an account of how certain features of ADHD (the truly undesirable ones?) are weakened (diluted) and/or mediated by environmental factors such as family, presumably 'good' family, management. Once again, the psychosocial repertoire is drawn upon to construct the family as being pivotal in conferring positive outcomes for children with ADHD.

The positioning of the grandfather in relation to the grandson is an interesting one to consider in this context because it is between these positionings that Alan's own position shifts as he moves between identifying with and distancing himself from the ADHD behaviours displayed by his son. Identification and distancing are achieved through processes of categorisation and particularisation (Billig, 1996; Potter and Wetherell, 1987). As Billig says 'the human mind is equipped with the two contrary skills of being able to put things into categories and to treat them as special' (1996:164); specific instances (of categories) are, thus, distinguished and split from the category in order to perform rhetorical work. Description of the grandfather's behaviour is used to provide evidence of his rightful 'fit' with the ADHD category. However, the splitting of the ADHD category into parts permits a distancing from the less desirable, or useful aspects of it (useful in interactional terms). The following statement by Alan demonstrates this: ***I've got a bit of the hyperactivity aspects but I don't think I've got any of the other.*** This statement fits within the context of a discussion on the genetic basis of ADHD, but,

crucially, comes just after his and Jane's description of his father's disruptive behaviour. Alan's identification with ADHD supports the genetic explanation of ADHD (as a category). However, his identification with the condition is only partial, and, thus, he also manages to distance himself from the problematic behaviours associated with his father. He does this through the use of particularisation, the use of minimising language (Potter, 1996) and also fuzzy, vague descriptions of ADHD behaviour (Potter, 1996; Macmillan and Edwards, 1998). Particularisation occurs in Alan's claim to 'have' one of the subtypes of ADHD, hyperactivity. It is interesting that several of the fathers, when identifying with their son's ADHD, tend to reference instances of hyperactivity, rather than any of the other sub-types, to support these claims (see Extract 15). Arguably, hyperactivity does have its merits with regard to its potential for multi-tasking and doing things quickly. However, too much hyperactivity risks being pathological and so Alan's identification with the condition is only partial. His use of **a bit** serves to minimise the effect (Potter, 1996) of his identification with ADHD, suggesting that his hyperactivity is not problematic, or pathological, for him. Interestingly, although Alan is unequivocal in naming and claiming the 'sub-category' hyperactive, he is far less clear when naming the other 'sub-categories' of behaviour associated with ADHD ***I don't think I've got any of the other***. Vagueness has a rhetorical function in that it can provide a broad categorisation of an 'entity' without the speaker being held to account over specifics (see Potter, 1996). The behaviour of Alan's father has been constructed to support a general category of ADHD, but it is unclear with which particular feature of ADHD this behaviour fits. The fuzziness of the description works rhetorically to prevent the undermining of Alan and Jane's assertion that his father's behaviour is symptomatic of ADHD. It also allows Alan's claim that he does not have any other of the behaviours associated with ADHD (or his father) to remain unchallenged, as, in this instance, ***the other*** (sub-types) are unnamed. It is

revealing that a little later in the interview Jane suggests that Alan is also impulsive (see Extract 16), which contradicts his claim here. Through processes of particularisation and vague categorisation Alan is able to identify with ADHD but also distance himself from the problematic behaviours displayed by his father.

Identification with and distancing from their sons is also accomplished by the fathers in this study through recollections of their own childhood. As identified by Singh (2003) fathers' recollections both pathologise and normalise their own childhoods, and these, respectively, work to construct identification with and distance from the ADHD category.

Normalising childhood behaviour: The active boy

Extract 16 continues immediately from the previous extract

Extract 16, Alan and Jane

Alison: *but you you mentioned it in yourself slightly the hyperactivity side of it but was that ever problematic for you?*

Alan: *I think my mum wanted four kids and she had me and I was number two and had no more (laughs)*

Alison: *(laughs) ok a problem for her then maybe?*

Alan: *uhm er what was your question again sorry?*

Alison: *I was wondering whether being hyperactive had ever been problematic for you? Whether a diagnosis would have helped you?*

Alan: *uhm probably help...yeah it may have given me more things to think about my mum would probably have just said I'm just just what does she call it? 'an active boy'*

Alison: *uh uh*

Alan: *I'm an active...and maybe that that thirty or forty years ago having an active outdoor boy was good and that was ok I was just active and on the go*

Jane: *I think because your behaviour was ok that was fine*

Alan: *yes that was probably the saving grace as such I was just always on the go*

Jane: *you know I think if you'd had any of the social ...*

Alan: *yeah*

Jane: *issues with ...I mean you're certainly impulsive*

Alan: *(whispers) no I'm not impulsive at all*

Jane: *I'd say extremely impulsive*

Alison: *(laughs)*

Jane: *'cos your attention can get I mean in a work situation you're very much you know you start lots of things but don't finish them so you would fit into a classic... apart from the uhm sort of inattention you don't have that well I don't find you have that need to control [...]*

Alan: *there's certain ways I like doing things and my team know that*

Jane: *but you're not inflexible*

Alan: *no yeah as long as it's my way then that's fine (laughs)*

Jane: *you know if I'm comparing to your dad your dad has very fixed views on how things work and the way they should be done and he wouldn't be swayed on any...*

Alan: *but then I deliberately break rules because of that*

Jane: *yeah he's very rigid whereas...*

Alan: *you know he goes 'well you're driving the wrong way down a one way street' 'yes it's a hundred yards it's fine don't worry about it'*

Alison: *(laughs)*

Alan: *I've calculated the risks it's ok [...] uhm I always had ants in my pants that's probably the lasting memory and probably a little bit more immature than the other boys in the probably in the excitableness of it I'd probably want to get excited about things more than others uhm I don't really remember much of (pause) school that's that's ... but I probably I probably was just wanted it all just couldn't sit still wanted to do things*

Alan's account of his own behaviour as a child is taken up by the interviewer as implying it was so challenging that his own mother chose not to have any more children. However, the suggestion by the interviewer that his behaviour may have been problematic for his mother is not taken up, and to some extent is resisted. Alan reports that his mother would have identified him as ***just [...] an active boy***. By establishing his mother as the author of this description, Alan manages his own neutrality in providing such a description. Through this use of footing (Potter, 1996; Goffman, 2001), Alan manages his own accountability for constructing himself as a, (perhaps) abnormally active, but, crucially, normal child. Throughout the remainder of the extract, Alan's position moves between identification with and distance from 'ADHD typical' behaviour' as he continues to construct his own childhood behaviour as abnormally normal. At the end of this extract, he offers a partial script of his own routine and typical behaviour as a child ***I always had ants in my pants*** and ***I'd probably want to get excited about things more than others***. The singling out of behaviours as warranting of description formulates them as exceptional (Edwards, 1994), and, in this instance, these behaviours work as documentary instances of the category ADHD (see Garfinkel, 1984). However, Alan's scripting of his own ADHD type behaviours is cautious and even vague. In particular, he uses minimising and tentative language (just, a little bit, probably) to underplay the effect of these behaviours. This works to resist pathologisation: ***I***

was just active and on the go and *probably a little bit more immature* and *I probably was just wanted it all just couldn't sit still wanted to do things*. The use of the idiom *I always had ants in my pants* is rhetorically useful as it is both vague and robust, thus, preventing the undermining of Alan's description (see Potter, 1996).

Again, through processes of categorisation and particularisation, Jane (and Alan to a lesser extent) distances Alan from the problematic behaviours associated with ADHD and, specifically, with his father. Alan's 'busyness' as a child is constructed as unproblematic because his *behaviour was ok* and he did not have any of the *social issues*. Jane's deployment of the somewhat vague descriptions of 'behaviour' and 'social issues' contributes to the broad category of ADHD. This vagueness prevents the undermining of Jane's positioning of Alan outside the ADHD category. Conversely, Alan is also distanced from the ADHD category through the particularisation of specific behaviours, namely, control and inflexibility, which again are suggested, by Jane, as indicators of ADHD, but which, interestingly, are not identified as such within the clinical narrative about ADHD (see DSM IV for a list of symptoms). She points out that she does not find that Alan has *that need to control* and when she describes Alan's father's inflexibility, Alan quickly interjects with an example of how his behaviour does not 'fit' that profile: *I deliberately break rules because of that*.

This section has discussed how fathers move back and forth between identification with, and distance from, their sons, and, from the ADHD category. Constructing identification with ADHD entitles fathers to make knowledge claims about the category. Fathers are, thus, through their experiential knowledge, positioned as experts with regard to their sons' behaviour. Such identifications can

also imply that ADHD is inherited rather than due to parenting and environmental deficits.

However, the subject position of ADHD father is a risky one to occupy as, being a pathological label, it risks positioning the father as an 'unreliable' witness, one that lacks credibility. Therefore, fathers work to distance themselves from the problematic and unhelpful aspects of ADHD. It is interesting that identification with ADHD is invoked through descriptions of hyperactivity and, in particular, of its usefulness at work (see Extract 14). Once again, the 'at work' father position is made relevant, and, significantly, their performance at work is enhanced through claiming some aspects of the ADHD category. In this case, through the particularisation of features of the ADHD category, fathers actually construct credibility and maintain their moral accountability.

8.7 Summary

This final data chapter has discussed how fathers of children with ADHD construct themselves as good, and morally adequate, fathers through the take-up of certain traditional, gender specific subject positions, namely, the disciplining father, the emotionally strong father and the out at work father. It argues that these subject positions are made available through the psychosocial repertoire of ADHD and through wider discourses of deficient parenting. Additionally, the chapter demonstrates how distinct domains of expertise are claimed by fathers and mothers in relation to their children's ADHD. Fathers are shown to move between a 'deficient' subject position (in relation to their partners' knowledge of their children) and an expert subject position (in relation to external contexts, such as schools). Finally, the chapter discusses fathers' identification with, and distance from, the ADHD father subject position.

Predictably, the subject positions taken up by fathers are distinct from the ones taken up by mothers and discussed in Chapters 6 and 7. This suggests that the discursive resources available for mothers are different to those of fathers.

However, one conclusion that can be drawn from analysis of the data across the four data chapters is that parent identities are not fixed, but are fluid and flexible. Identities are constructed and reconstructed across different contexts to perform distinct rhetorical business.

Chapter 9 Reflections on the research process: A postscript to the data chapters

9.1 Reflections on the methodology

In this brief chapter, I discuss some of the key issues and dilemmas that I encountered both in the setting up of the research and in the analysis of the data.

Setting up the research: Issues of identity

In the following section, I reflect on my active role as an interviewer and how that might have impacted on the talk produced within the discussion groups and interviews. These considerations are raised in (reflective) response to Potter and Hepburn's (2012) critique of the open-ended research interview, or, at least, their critique of how such interviews are often conducted. One of the criticisms they raise is with regards to the lack of transparency in accounting for the set-up of the interview situation. Similarly, they call for more transparency when describing the role of the interviewer.

Certainly, reflection on the research process undertaken in this study raises considerations of what kind of identity formulations were being encouraged and constrained in the interview set-up. Recruiting via parent support groups might privilege certain parental accounts of ADHD. As Robb (2004b:400) says, 'the design of the research study can deliver important if implicit messages about the kinds of identities and values being privileged'. As discussed in Chapter 7, being a member of a parenting support group confers certain category bound activities that are constitutive of the category itself (see Stokoe, 2003; Sacks, 1995; Widdicombe and Wooffitt, 1995). Certainly, the category 'parent in need of support' formulates a deficit account of family life in contrast to the undefined and uncategorised, 'normal' account of family life. Such parents are typically understood as in need of support because of difficulties experienced in the practice of parenting. In

recruiting parents via such support groups, the identity of the 'parent who experiences difficulties' is made implicitly relevant. 'Abnormal' parenting practices and experiences are further invoked through the call for parents to share their 'experiences of parenting a child with ADHD' (rather than just 'parenting'), a call, which formulates these practices as distinct and out of the ordinary. As I discuss in Chapters 5 and 7, it is significant that parents' accounts orient, initially, at least, to descriptions of their children's abnormal and difficult behaviour, and how this serves as warrant for 'abnormally' authoritative parenting practices. As Potter and Hepburn (2012:558) suggest, through the recruitment procedure, a particular category membership is made relevant and central to the interview. It is this category that is 'made central, formulated and reworked' in the research process. It is easy to slip into making assumptions that these respondents (that is, the parents who came forward for this study) are somehow representative of a wider population (that is, all parents of children with ADHD).

Inviting parents to talk about their experiences of having a child with ADHD, inevitably, attracts parents who are invested in 'involved' parenting. As Robb (2004b) suggests, the appeal to parents 'to share' their experience implicitly privileges a reflexive model of parenting. This again, raises considerations of what parenting identities are excluded from this research.

It is also important to consider how the parental identities formulated within the research process are informed by the participants' positioning of the researcher and their understanding of the research. The invitation and information sheet (Appendices A and B) were distributed via the gatekeepers of the two support groups. Arguably, this positions me as a person who can be 'trusted' and who is, potentially, sympathetic to parents' accounts of their experiences. Similarly, in the introduction to my research, I position myself within the faculty of Health and

Social Care, arguably, a faculty whose title carries a certain benign and sympathetic status. In addition, in my letter of introduction to one of the groups (Focus Group 1), I also position myself as a part-time counsellor. It is possible that parents identified the research as one whose intention was to be supportive of the parenting experience. The participants were, certainly, very generous of their time and very open with their accounts. I did not experience any particular overt resistance or suspicion from the participants who took part in the research. Participants, in accounting for their reasons for taking part in the study, were, themselves, keen to express their desire to 'help other people' in similar circumstances. Drawing upon the notion of reciprocity mentioned in Chapter 4, the collaborative 'feel' of the research process can be interpreted as having been mutually co-constructed by the participants and the researcher. Building affiliation between researcher and researched can be seen as a way of limiting possible challenges to, on the one hand, respondents' accounts, and on the other hand, researcher questions and interpretations.

The identity of both researcher and researched are, potentially, at risk in the research encounter. In this particular research situation, the positioning of parents as 'objects of research' has particular pertinence in relation to their accounts of being the objects of scrutiny and surveillance. Once again, the research situation places them under scrutiny and their accounts of their experiences of parenting a child with ADHD risk being undermined and challenged. They risk, through the research process, being positioned as unreliable and irresponsible parents. In contrast, the researcher is at risk of being positioned as one of the uncaring professionals, formulated throughout the research process (in parents' talk) as both ignorant and judgmental. It is beneficial to both parties, therefore, to construct a collaborative working relationship, which does not threaten to undermine the identities formulated within the confines of the research situation.

I made clear I was a research student at the Open University when recruiting from both support groups. However, I only identified myself as a counsellor to the support group from which I recruited focus group 1. Interestingly, the talk within this group oriented much more to stories of distress and extreme emotional hardship. In addition, the individual 'turns' were much longer within this group. This, perhaps, indicates that participants were orienting to my role as a counsellor and making relevant certain situated behaviours, normally associated with a counselling context. I did not identify myself as a counsellor to the second group, and in the talk prior to the commencement of the focus group, much more was made of my academic background as a psychologist. I felt positioned much more as an academic by this group, and, interestingly, some of the talk of this group oriented to the professional and expert status of two of the mothers, partially, in relation to their knowledge of ADHD, but also, I feel, in relation to their status as professional women. Certainly, in this focus group, there was more of a scientific, medicalised focus in their descriptions of their children, coupled with an emphasis on successful parenting strategies and skills.

Dealing with co-morbidity

An unanticipated dilemma that the research raised was the issue of co-morbidity. With hindsight, perhaps, this should not have been so surprising. A quick search of the research databases with the search terms 'ADHD' and 'Co-morbidity' accesses over 200 journal articles. Much of the literature referred to in this thesis also acknowledges the prevalence of co-morbid diagnoses (Moncrieff and Timimi, 2013; Remschmidt, 2005; Sonuga-Barke, 2005). Common co-morbidities of ADHD include anxiety, conduct disorder, oppositional defiant disorder, autism spectrum disorder and Tourette's. Moncrieff and Timimi (2013) suggest that co-morbid diagnoses account for two-thirds of all ADHD diagnoses.

It is interesting that, despite the initial call for participants who were ‘mothers and fathers of a child with ADHD’, through the research process, it became clear that the majority of the participants had children who presented with co-morbid symptoms or had a co-morbid diagnosis. This is neither surprising nor problematic for an epistemological approach underpinned by social constructionism. Unlike the restrictive assumptions of a scientific, positivist approach, which seeks to ‘fix’ the meaning of such medical categories as ADHD, a social constructionist approach acknowledges the ‘messiness’ of such labels (see Horton-Salway, 2004). Contrary to policy documents, such as NICE (2009), that claim ADHD to be an ‘easily identifiable, discrete disorder’ (Moncrieff and Timimi, 2013:63), a social constructionist approach understands the meaning of medical categories to be flexible, fluid and blurred. These categories are not understood to have a pre-existing, external reality but are understood to be constituted through the discursive activities in which they appear. Excluding parents whose children did not ‘fit’ the ‘exclusive’ ADHD category definition could be interpreted as an attempt to ‘fix’ the meaning of ADHD and would contradict the ontological and epistemological underpinnings of the theoretical approach to the study. Indeed, this research study is concerned with *how* parents *construct* their understanding of this complex and controversial category. It is completely legitimate that parents might, at times, emphasise, or foreground, the ‘ADHD part’ of their child (as they did, presumably, in coming forward for this research project) while at other times emphasise other aspects of their child’s behaviour. Although the recruitment procedure brought forward parents whose children had co-morbid diagnoses, suggesting that ADHD is not an ‘easily identifiable, discrete order’ but one which overlaps with other conditions, it is interesting to note that co-morbidity was not raised as potentially problematic for this study. None of the parents mentioned it to me during the recruitment process, nor checked that their children’s diagnosis was

an appropriate one for the study. Similarly, although the recruitment process might point to there being some fuzzy boundaries between medical categories, parents' talk conveys their clarity and certainty about which of their child's behaviours belong to which category of disorder. The following two extracts are from Paula (Extract 1) and Caroline (Extract 2). Paula has just explained that her son has ADHD, autism and Tourette's whereas Caroline has just explained that her son has ADHD, Asperger's and dyslexia.

Extract 1, Paula

Paula: *it's just knowing what's going on cos you sometimes get an overlap with the three of them so he can start becoming quite hyperactive and impulsive because of the ADHD but then the autism is there and that makes him a bit anxious and then that sets his tics off and you know and it just manifests as quite a difficult uhm mixture to deal with and school are experiencing that in the afternoon cos medication doesn't last as long as it used to cos he's bigger*

Extract 2, Caroline

Caroline: *[.....] the Asberger's side of things was being handled fine [...] but the ADHD and the dyslexia were not [...] and that's where the difficulty was lying that the impulsivity wasn't understood [...] and the impulsivity... er that combined with the dys...the problem of the dyslexia that when he was frustrated he reacted uhm but ... and they ...and the concentration they just felt that he should be able to do it and of course with the dyslexia he couldn't do it anyway*

In both of these examples, the complexity of their respective child's condition is worked up. Parents' accounts of complexity perform several discursive functions; in reproducing formulaic accounts of ADHD, parents risk being accused of jumping

on the ADHD bandwagon (see Horton-Salway, 2007). As Horton-Salway argues, in distinguishing their own accounts from 'formulaic' accounts, parents are contributing to the construction of their child as a 'genuine case'. Secondly, accounts of complexity such as the two extracts above, are often used to contrast the inability of external bodies (such as schools or the medical profession) to deal with the presentation of such 'disordered' behaviour with the ability of the parents (typically, mothers) to identify, and, crucially, cope with such behaviour. Finally, in allocating different behaviours to different medical categories parents are constructing themselves as knowledgeable and expert with regards to their children. In this way, complex category construction is used in the performance of identity work, particularly, in the accomplishment of the good parent identity. Arguably, parents partially accomplish this 'good' parent identity through the very act of volunteering as a suitable respondent for the research. Coming forward is, in itself, a discursive act. Perhaps it is not the role of the researcher to impose category restrictions.

Issues of analysis: Hiding the interviewer

A concern raised by Potter and Hepburn (2012) regarding open-ended interviews is that data analysis very often obscures the questions put forward by the researcher. These questions, they argue, are crucial to what is produced by the participant. Whilst they acknowledge and accept the position that data analysis is a representation, and is, consequently, always partial and incomplete, they suggest that this is an easy justification to hide behind and can be used to justify 'loose' research. In such research, they suggest, participants' talk is typically presented without indicating the interviewer's questions, 'agreement responses', such as 'mmm' or 'uh uh', or any prosodic features, such as intonation, stress or tone information. Therefore, there is a risk, they argue, that extracts from participants' talk are constructed as 'standalone' declarations, rather than

examples of interactions embedded within a discursive context. They suggest that interviewers' questions and responses can be interpreted as a 'subtle coaching of participant in a relevant social science agenda' (2012:565). Encouraging noises, such as 'mmm' and 'huh huh' reveal to the participant that this type of talk is 'good' and desired, and there is a danger that the researcher, inadvertently, perhaps, encourages accounts which are of interest to them (for a summary of the function of such noises, see O'Reilly, 2005). Potter and Hepburn (2012) call for much more transparency in recording and analysing this active interviewer role.

With regard to my own analysis, I am aware of being largely absent from the data I present within the data chapters. First, as a PhD candidate, I have a stake in presenting an authoritative account of myself as a competent researcher, and a competent interviewer. On occasions, I have been embarrassed by the quality of my questions. In selecting data for presentation within the chapters, I have carefully considered how such questions have impacted on the production of ensuing accounts, and while acknowledging the possibility of bias, I have excluded any remarks which I consider redundant and unhelpful to the analysis. However, I have not excluded them from the full transcript.

Secondly, as a counsellor, I am trained not to ask too many questions, and not to make too many interventions. Although I was very determined not to blur the interviewer role with the counselling role, the very 'set-up' of inviting a stranger to talk about their past and current experiences does resonate with a therapeutic situation, and does offer therapeutic opportunities, as suggested by Birch and Miller (2000). I found this particularly true of the one-to-one interviews. However, despite relatively few questions, my transcription does reveal that I use encouraging responses quite a bit, ostensibly as a mark of attentive listening, but, arguably, also as way of encouraging more on a particular topic. A focus on the

micro level of interaction and the role of the interviewer in the production of accounts is not really the concern of this research, which is much more concerned with parents' use of culturally available resources in local interactions. Therefore, I have not included all of these encouraging responses in the excerpts provided in the data chapters. In addition, such micro analysis would, I feel, also need to include facial and body gestures for it to be fully meaningful. Again, as a counsellor, I am trained to use my face and body to express attentiveness, empathy, or confusion, and these gestures, in their own way encourage or inhibit talk.

Potter and Hepburn's call for transparency (2012) is partially overcome by providing a detailed transcript of discussion groups and interviews. As Gray (2008) argues, detailed transcription in the Jefferson style is an extremely useful tool for fine-grained analysis. However, it is a particularly complex tool which consists of 'obscure conventions to those outside the field' (Gray, 2008:241). In addition, even a very detailed Jeffersonian transcript could not really provide details on the contribution of body gestures to the production of accounts. The transcript I provide follows simplified transcription conventions, which, as Gray (2008) argues is appropriate for a discursive approach that synthesises micro and macro discursive traditions.

9.2 Summary

In this chapter I have presented the most salient issues and dilemmas that I encountered during and post data collection. Although not a definitive list of issues, these are the ones that, I believe, have had most influence on my interpretation of the data, and, so, I have outlined them prior to summarising my key analytic interpretations of the data, and prior to offering some suggestions for future research, both of which I do in the next, and final chapter of the thesis.

Chapter 10 Conclusions

This thesis has taken a discursive approach to the talk of parents of children with an ADHD diagnosis. It has adopted a synthetic approach to discourse (Wetherell, 2007) and draws on analytic concepts associated with both conversation analysis and with discursive approaches more concerned with wider social context. The concepts of interpretative repertoires (Edley, 2001a; Potter and Wetherell, 1987; Gilbert and Mulkay, 1984) and subject positions (Edley, 2001a) have been used to synthesise the micro concerns of conversation analysis and the more macro discourse approaches. This discursive approach provides a useful framework for considering what discursive resources are drawn upon by parents in formulating the category of ADHD, and for considering what subject positions (or representations of self) are made relevant by the parents in their talk. The thesis has argued that prevalent understandings align ADHD with ineffective parenting. Consequently, this places parents at the centre of a highly moralised debate. Analysis of the talk of the parents who participated in this study suggests that the social category of ADHD is fluid, contradictory, and imbued with a moral discourse that is linked to competing subject positions. Key to all this is the way parents attend to issues relating to parenting and parenting practice and, significantly, the ways in which they take up certain argumentative positions within contemporary discourse about good parenting.

This final chapter begins by summarising and synthesising the key analytic interpretations presented in earlier chapters in relation to the research question and the three research aims set out in the introduction. It then considers the thesis' research contribution, and possible applications. The final section discusses some of the limitations of the study and makes suggestions for future research.

10.1 Analytic Interpretations

Privileging the biological repertoire

This study has shown how parents draw upon the biological and the psychosocial repertoires to construct their understanding of ADHD and how these repertoires make relevant very different subject positions and identities for parents and their children. It has found that, perhaps unsurprisingly, most parents in this study draw on the biological repertoire when explaining their understanding of ADHD. Claims of a biological cause for ADHD are supported by accounts that invoke brain and, in particular, genetic explanations. Perhaps reflecting the increased scientific emphasis on the genetic causes of ADHD, many of the parents within this study drew on genetic explanations when accounting for their children's ADHD. Interestingly, parents drew on their developing understanding (and expertise) of ADHD to reflect, often retrospectively, on their extended families. Grandparents, aunts, uncles, mothers and, more usually, fathers were, by different participants, described as displaying features of ADHD (and/or autism).

This thesis has argued that the biological repertoire is privileged in parents' accounts because the alternative psychosocial repertoire makes relevant the subject position of the normal, but socially deviant, child which, in turn, invokes moral judgements about naughty children, poor parenting and the state of society. Typically, parents align the psychosocial repertoire with old-fashioned or out-of-touch ideas of ADHD. Sceptics, including professional experts who reject biological explanations of ADHD, are constructed as unenlightened and/or ignorant. In this way, parents' take up of these repertoires can be seen to do rhetorical business, in particular, undermining and resisting their moral positioning as ineffective parents.

This study has demonstrated that while the biological repertoire is the most prevalent account of ADHD drawn upon by this group of parents to explain their child's ADHD, mothers and fathers do engage with ADHD in different ways. Interestingly, fathers' explanations of ADHD are particularly variable and potentially dilemmatic. Although, in some contexts, fathers work to undermine sceptical approaches to the biological/medical explanation of ADHD, in other contexts, they position themselves as somewhat sceptical of the medicalization of their children (supporting previous work by Singh, 2003). In particular, fathers' accounts of their sons' behaviours tend to be less problematic than mothers' accounts, and fathers, within certain contexts, explain their son's behaviour in terms of it being 'typical of boys'. This is a tricky position for fathers to occupy as this explanation of behaviour is one given by the ADHD sceptics, and it is certainly not one that fathers present in all contexts. Explanations such as 'boys will be boys' are typically offered by the fathers in this study when identifying with some of their sons' behaviours. One possible explanation for this is that fathers' identification with their sons usually appears when the context turns to genetic explanations of ADHD, specifically, genetic accounts which suggest ADHD traits are passed from father to son. Clearly, within these accounts, in problematising their sons, fathers risk pathologising their own behaviour and, so, in this sense, an investment in the medical label puts their own identity at stake.

Despite some variability in accounts, the biological explanation of ADHD is the most prevalent one in this study. However, a medical pathway can be morally problematic for parents in terms of claiming responsibility for their child's (medical) welfare. The biological/medical repertoire constructs the child as warranting medical intervention; responsibility and power for managing the 'medical' condition resides with medical authorities. However, parents of children with ADHD are positioned within debates that align their children's deviance with their own lack of

parental responsibility. So, not demonstrating responsibility is potentially risky. While all the fathers and mothers draw on the biological repertoire to account for their child's ADHD, they also provide accounts which construct their own responsibility and their own entitlement to responsibility, for their child's medical wellbeing. One of the ways this is done is through distinct claims to expertise. Interestingly, fathers and mothers draw on different knowledge claims to challenge the medical narratives that shape theirs and their children's experience. For example, in relation to medication, mothers demonstrated their responsibility towards their sons by allowing them to take medication breaks, or by reducing dosages. Mothers draw on their knowledge of 'what is good' for their child. 'Fine-tuning' medication is part and parcel of their role as managers of their child's welfare. Fathers, on the other hand, demonstrate their responsibility towards their sons by testing the medication they were giving them. Fathers draw on this experiential knowledge as 'proof' that they are not giving their sons anything harmful. The fathers who took their son's medication talked of the 'slowing down' effect on their brain. By drawing on such experiential knowledge in their accounts of medication, these mothers and fathers are able to negotiate the problematic issue of responsibility in relation to their child's wellbeing. This thesis has demonstrated that responsibility for managing ADHD (and their children) shifts between medical authority and parents depending on what is at stake. Through accounts of resistance and challenge, parents attend to issues of power in relation to their parental entitlement to have ultimate responsibility for their children. In assuming responsibility for their children, they can be understood to be doing their duty as morally adequate parents.

Constructing the good parent

It is notable that all the parents in this study do considerable discursive work to formulate themselves as good parents. They accomplish this through the

deployment of rhetorical strategies when attending to issues of accountability relating to their children's ADHD.

The thesis has shown how, through discursive and rhetorical techniques, such as reported speech (Chapter 6), the objectification of complaints (Chapter 5) and building epistemological warrant (Chapter 8), parents accomplish moral adequacy. This is often achieved by juxtaposing their own constructed (moral) behaviour/position with the behaviour of others, constructed as being morally inferior. Doctors and health visitors, are, typically, constructed as being ignorant or out of touch if they do not endorse an ADHD diagnosis, other parents are constructed as being judgemental, even bullying, and teachers are constructed as being ignorant in their understanding of ADHD.

In addition to these rhetoric strategies, parents also draw on culturally available discursive resources when constructing themselves as morally adequate, good parents. Significantly, these resources often make relevant traditional/historic and gendered subject positions, such as the valorised/blameworthy mother and the disciplining, out-at-work father. Although children did not participate in this study and do not feature as a standalone chapter, children are very much present in the accounts of parents. In particular, the way children are constructed by their parents serves to formulate parents' own identities. Parent identities are formed in relation to their children's. I discuss the representation of children in my summary below of the subject positions made relevant by and for mothers and fathers.

Subject Positions: Mothers

This research has shown how the binary subject positions of blameworthy and valorised mother are made relevant by the mothers in this study and how particular discursive practices are deployed to resist being positioned as deserving of blame. The blameworthy subject position is resisted through accounts which

draw on the biological repertoire, accounts which construct abnormality, accounts which construct mothers' agency in relation to medication and, finally, through accounts which construct victim and perpetrator identities. The valorised mother subject position is taken up in accounts that work up abnormality, both of their child (or children) and of the requirements demanded of their parenting practices. In such accounts, mothers construct themselves as skilful managers of their child's abnormal behaviour, and, as proactive advocates prepared to do battle on their child's behalf. This construction of the valorised mother is enabled through a parallel construction of the child as victim. Conversely, the valorised mother subject position is also made relevant through accounts which *normalise* their experiences in an attempt to defend themselves against possible accusations that they are, in some way, deviant and pathologically responsible for their child's disorder. Accounts of 'normal' mothering (parenting) are provided as a way of undermining a moral imperative to attend parenting classes. Mothers also use such accounts to resist being positioned as tragic and in need of sympathy.

Abnormal and normal mother/child dynamics are, typically, formulated in accounts of coping and managing, and are used to construct more positive maternal identities than the ones frequently espoused in popular/media representations of ADHD. The variability of abnormal/normal accounts which make relevant the good mother subject position highlights the dilemmatic nature of current ideology relating to good mothers.

Subject Positions: Fathers

Moral accountability is also a concern of fathers in this study. Fathers construct themselves as good, and morally adequate, fathers through the take-up of certain traditional, gender specific subject positions, namely, the disciplining father, the emotionally strong father and the out at work father. I argue that fathers make

relevant these, quite old-fashioned, subject positions in an attempt to undermine being positioned as an ineffective parent. Contemporary political and media discourses align deficient parenting with deviant and troublesome children. The psychosocial repertoire of ADHD makes available the deficient parent subject position. In particular, 'unruly' behaviour is linked with a lack of discipline or authority in the family. Both mothers and fathers work to represent themselves as 'good' parents and to undermine those subject positions made relevant by the psychosocial repertoire of ADHD. Mothers demonstrate this, mainly, through accounts of their own parenting skills and their use of effective strategies. Fathers, on the other hand, orient to charges of a lack of discipline and formulate themselves as disciplining and authoritative fathers. The take-up of this subject position by fathers is an interesting one and highlights the variability and fluid nature of discourse and identities. In certain contexts (contexts that demand the undermining of sceptics), discipline is constructed as old-fashioned and out-of-date. In other contexts, however, (contexts that demand accounts of good parenting), discipline is constructed as necessary, reasonable and maintained. Variability is anticipated within a discursive approach as language is understood to be indexical and dependent for its meaning on the context. It is expected that meanings and 'truths' vary according to the demands of the context.

Biological explanations for ADHD permit parents to occupy the subject position of expert parent. This research has shown how distinct domains of expertise are claimed by fathers and mothers in relation to their children's ADHD. Fathers are shown to move between a 'deficient' subject position (which is compensated by their partners' knowledge of their children) and an expert subject position (in relation to external contexts, such as schools). The 'deficient' father subject position (at home) is a potentially risky one for fathers to assume with so much critical attention directed towards parents of children with ADHD. Fathers mitigate

this by making relevant other 'good father' subject positions, such as the 'out at work' father and the 'emotionally strong' or 'supportive' father. I have argued that fathers can risk the 'deficient' father position because they have alternative positive subject positions they can occupy. Certainly, it is interesting that mothers' constructions of themselves as good mothers are usually worked up in accounts of mother/*child* relations. Constructions of the good father, are, however, more typically, worked up in accounts of father/*family* relations.

Fathers' accounts of the effectiveness of the medication also work to establish fathers' identification with their son's condition. Many of the fathers in this study identified with aspects of their son's ADHD behaviour. As well as conferring fathers with epistemological warrant in relation to ADHD, by identifying with their son's disorder, fathers can be seen to be resisting the pathologisation of their child's (and their own) behaviour. Particularly notable was fathers' identification with hyperactivity, which was constructed as being unproblematic and, even, useful within a work context. This, in turn, permits fathers to construct their son's possible futures, in particular, in relation to working life. Similar to mothers' constructions of normality, identification with their son's disorder can be seen as fathers' attempts to resist their own, and their son's, positioning within a tragic narrative.

Above all, the data chapters reveal that through the take up of diverse subject positions, parenting identities are not fixed, but are fluid and flexible for use in argument. These identities are constructed and reconstructed across different contexts depending on what is at stake. By using different discursive resources, mothers and fathers construct distinct parenting identities. However, overall, these distinct parenting identities are formulated to convey the idea of a morally adequate and balanced parenting team.

The thesis has shown how in the case of contested social phenomena, such as ADHD, arguments, justifications and dilemmas are part of the cultural resources of a society, and these are drawn upon and revealed in everyday discourse in the formulation of identities.

10.2 Research contribution

The thesis has drawn on three key bodies of literature: literature relating to ADHD, literature relating to parenting and ADHD, and, literature relating to discursive approaches. This next section will consider how this thesis contributes to each of these existing literatures.

ADHD: A moral category

Chapter 2 highlights three dominant and competing explanations for the causes of ADHD. First, that it has an organic provenance. Second, that it is socially produced. Third, that it is the combination of environmental factors and a genetic predisposition to the disorder. Contemporary research reflects these concerns with significant efforts being made towards seeking biological and genetic explanations (Remschmidt, 2005). Criticism of such approaches is informed by academics, such as Conrad (2006) and Timimi (2007), who are sceptical of the disorder as a medical category and raise concerns over its use as a mechanism for social control. These polarised positions make available a third, and, increasingly, common route for current research, principally, the combined effects of genetic and environmental factors in the production of mental health disorders such as ADHD (Sonuga-Barke, 2005; Singh, 2008a). Certainly, this seems to be a significant area of contemporary research interest, with many ADHD researchers (Gray, 2008; Cooper, 2008, 2001; Sonuga-Barke, 2005; Singh, 2002b,) calling for a biopsychosocial approach, which integrates biological and socio-cultural aspects. Common to all these research approaches is a concern with fixing the

meaning of (and explanations for) ADHD, whether it be biological, biopsychosocial or an example of the medicalization of social deviance. These approaches do not, however, concern themselves with the constitutive nature of these explanatory models.

Further to work by, for example, Horton-Salway (2012, 2011), Gray (2008), Harwood (2010) and Bailey (2010, 2009), the critical discursive approach adopted within this study has interrogated the assumptions of these dominant explanations of ADHD and rejects the notion that such medical categories are objective and neutral, existing independently of the individual. This thesis adds to the critical body of health literature which argues that categories are not only constructed socially, but also contribute to the construction of social identities. In particular, it has shown how the ADHD category is invoked as a moral category and how parents are implicated within this. It has demonstrated that competing versions of ADHD perform distinct moral work, and make relevant very different subject positions for the individuals implicated by the categorisation.

These findings contribute insight into the constitutive nature of the ADHD category and offer understanding of how this, in turn, may be to some extent implicated in the rise in ADHD diagnostic rates. As Gray (2008) suggests, in challenging the underlying assumptions of contemporary ADHD explanations, a critical discursive approach, such as this one, is particularly warranted at a time when, despite its controversial status, the DSM's medical classification of ADHD presents itself as 'the truth' and the everyday understanding of ADHD within many cultures is that it is a valid neurological disorder.

Parents of children with ADHD

As outlined in Chapter 3, existing literature relating to parents and ADHD is underpinned by either an interpretivist or positivist research philosophy and is

primarily located within the sociological/social psychology and developmental disciplines, respectively. Following Gray (2008), it highlights that most sociological research is concerned with, uncritically, reporting the subjective experiences of parents while most developmental psychological research is concerned with identifying causality in relation to ADHD. Despite differences in epistemology, both these approaches share an uncritical stance towards language; language is understood to be a transparent route to the underlying and 'privately owned' experience and beliefs of the speaker. This uncritical stance towards language contrasts with the critical approach taken by this study.

This research study adds to a growing body of work which adopts a critical perspective on ADHD and parenting (Gray, 2008; Mchoul and Rapley, 2005; Singh, 2005, 2004, 2003, 2002a; Malacrida, 2004, 2001). With the exception of Mchoul and Rapley's study, which adopts a conversation analytic approach, and Gray, who adopts a synthetic approach to discourse, the focus of much of this critical work situates parents' (typically, mothers') experiences of ADHD within a very broad context of discursive practices (see Singh, 2004, 2002a; Malacrida 2004, 2001; Todd and Jones, 2003; Norris and Lloyd 2000). The focus in these studies has mainly been on how mothers are positioned within grand social and cultural discourses, and how power is deployed through these discourses (and resisted by mothers). As argued in Chapter 3, emphasising the powerful nature of dominant discourses such as medical classifications, potentially, risks undermining or, at least, ignoring mothers' (and fathers') own understanding and construction of ADHD within local interactions. This research study shifts the emphasis away from the dominant discourses and focuses instead on the talk of parents in interaction. With the exception of Gray (2008), there is very little previous work on the talk of parents in relation to ADHD, and even less on fathers and the relationship between mothers' and fathers' accounts. The synthetic approach adopted for this

study provides new insight into how parents manage identity and accountability in relation to ADHD within the immediate context, while considering this accomplishment with reference to the resources available within the broader social context.

This research has demonstrated that parents are concerned with accomplishing a moral, 'good parent' identity in relation to their children's ADHD diagnosis. The take up of the biological repertoire absolves parents of responsibility for their child's ADHD, and, in adopting this interpretive repertoire, the subject position of the 'sick' child becomes available. This, therefore, legitimises parents' pursuit of medical treatment for their children.

Mothers are significantly privileged in the existing body of research relating to parents and ADHD. This study adds to a growing body of work which acknowledges the absence of fathers in this literature. This research contributes to the literature relating to fathers and ADHD. It critically examines and offers insight into the discursive practices employed by fathers. These discursive practices are analysed in relation to the way available cultural resources are drawn upon to accomplish moral work in highly situated interactions.

Perhaps one of the most important contributions of this thesis is in the light it sheds on how fathers draw on culturally available resources in the local performance of moral identity. This not only fills a significant gap in the research on this area of parenting a child with ADHD but also highlights some of the issues raised for fathers in talking about the health and well-being of their children, the challenges this presents for them, and the dilemmas that they need to manage in discussing how they (the fathers) play their part in the parenting team.

Discursive psychology

Critical discursive psychology is an increasingly common approach within critical health studies and is a useful approach when considering contested categories, such as ADHD. It has, for example, been useful in (re)theorising ME (see Crix, Stedmon, Smart and Dallos, 2012; Horton-Salway, 2007, 2004, 2001, 1998). This research adds to this existing body of critical discursive psychology in relation to contested medical categories.

The adoption of a synthetic approach to discourse adds to a growing body of work relating to gender and health practices (Seymour-Smith, 2008), gerontology (Jones, 2003) and masculinity (Wetherell and Edley, 2009, 1999), but it has been little used in relation to contested health categories, and with the exception of Gray (2008), has not been applied to the topic of ADHD. It builds on Gray's research, supporting and developing her claims relating to the moral positioning of parents. In particular, it provides new insight into how fathers draw on culturally available resources in the local performance of parenting and moral identity and how mothers' and fathers' accounts are relational.

This research also builds on work by Horton-Salway (2011), which utilises the analytic concepts of interpretative repertoires and subject positions in relation to (media representations of) ADHD. This research develops new insight into how these repertoires are taken up by parents and to what effect, and considers what subject positions are made relevant by parents in their talk and how they manage the dilemmas arising from these. It is significant that there is considerable mirroring between what is talked of in the newspapers and the cultural categories that parents draw on in their talk about ADHD.

The thesis also discusses the polarisation of scholarly views in relation to approaching discourse with either a micro lens or a macro lens and it also

acknowledges the potential criticism that a synthetic approach might generate for those who regard the two as incompatible. However, such an approach has proved to be a particularly fruitful one to the analysis of parents' talk about their experiences of having a child with a diagnosis of ADHD because it has permitted an exploration of the variable ways in which parents draw on wider cultural resources to construct moral identities in telling of their experiences. A CA approach would, for example, restrict the collection of data to natural occurring contexts, such as medical encounters. In these contexts, parents do not necessarily have the chance to give narratives. A synthetic approach is particularly relevant for studies interested in the construction of identities. As Holstein and Gubrium (2000) argue, the discourses, or resources, that are used in the construction of identities are available at the local as well as the wider social context. Analysis, therefore, needs to pay attention to the situated nature of accounts as well as the social structures within which they are constructed (see Burr, 2003). As such, a synthetic approach combines the study of *how* identities are made with the study of *what kind* of identity is made (Wetherell, 2007). It is through such a combined approach that we can achieve a fuller understanding of people's investment in certain subject positions. For example, analysis of talk-in-interaction has revealed *how* fathers construct themselves as disciplining fathers. Such analysis has permitted an understanding of *how* fathers attend to issues of (moral) accountability for the actions and events they describe through examination of the performative function of their talk and the way their accounts are constructed as factual. An awareness of the wider social explanations for ADHD also helped to make sense of why fathers in this study formulate themselves as disciplining and authoritative. Additionally, awareness of wider social discourses also helped to explain variability and potential contradictions in accounts. The analysis has highlighted how accounts of discipline as necessary

and reasonable (vis-à-vis fathers' identity) can exist with contradictory accounts of discipline as out-of-date and unhelpful (vis-à-vis the identity of the sceptics). This points to the existence of an ideological dilemma (Billig, 2001) around the notion of discipline, which provides insight into why such accounts can be imbued with contradiction.

This research has demonstrated the usefulness and applicability of such an approach, and in so doing, contributes to further justification of and support for a synthetic approach to discourse.

10.3 Possible Applications

This research provides further insight into the 'meaning' of an ADHD diagnosis for parents. Similar to Gray's findings (2008), it suggests that the two dominant ways of understanding ADHD, through either the biological or psychosocial repertoire, make available distinct subject positions for parents. These subject positions invoke parental responsibility (or lack of responsibility) for their children's ADHD diagnosis. This research reveals that parents orient to issues of responsibility and blame in their talk about ADHD, and, in particular, they do much work to present themselves as 'good' parents, both individually and as a team.

Clinically, this has several implications; first, in relational terms, professionals need to be mindful of the stigma that parents potentially experience, and need to manage in having a child with ADHD. Further to Todd and Jones (2003), this research suggests that encounters with others, including medical practitioners, can be perceived as morally risky for such parents. The identity of the good parent becomes particularly salient in such encounters and this, it is suggested, is what much of the discursive work orients to within such situations. It is suggested by Harborne, *et al.* (2004) that parents who feel blamed by professionals are unlikely to engage openly in the therapeutic process. The discursive analysis in this study

suggests that it would be helpful for health practitioners to understand more about what is at stake for parents when they talk about their children's ADHD and to understand the dilemmas parents face in giving accounts of their child's behaviour and parenting. Parker and O'Reilly (2012:462) identify the tension that is created within such therapeutic contexts 'where blame and accountability are paramount' and suggest that professionals might be at risk of colluding or aligning themselves with parents, who, in the process of managing their 'good parent' identities put forward accounts of their children's ADHD which constrain alternative understandings. A greater appreciation of the ways that parents are positioned in competing explanations of ADHD would be helpful. It would also be useful for practitioners to be aware of the routine and institutionalised forms of mother-blame and gendering that there may be in the process of referral, diagnosis and the care of the children with ADHD.

The findings of this study support previous research by Holt (2011, 2010), which suggests that parents resist being positioned as parents in need of parenting classes whilst, at the same time, apparently engaging with the classes. Not engaging with classes risks positioning them as defiant and uncooperative and, therefore, lacking in moral responsibility for their children. However, similarly, taking up the 'advice' given, also positions them as parents 'in need' of moral guidance. This research, therefore, raises awareness of how parents are morally positioned by such therapeutic interventions and how this might constrain parents' engagement with such interventions. However, caution should be applied to this interpretation, as it places, once again, the focus on parents' (lack of) engagement with the classes, which leaves the classes free from interrogation and risks positioning parents within another 'responsibility' debate. Conversely, therefore, this research also suggests that the effectiveness and impact of such classes might be questionable.

Another particularly significant implication for health professionals is that the linguistic and cultural resources available to talk about ADHD, parenting in general, and gender stereotypes constrains parents, medical professionals and 'the public' in the debate about alternative understandings, diagnoses, and treatment and management of children's behaviour. For example, the moral positioning of parents in relation to ADHD might explain the, reportedly, very pro-active stance that parents (mothers, at least) take in pursuing a physical explanation for an ADHD diagnosis.

The moral positioning of parents is concurrent with the polarisation of biological and psychosocial explanations for ADHD. Such a polarisation implicates moral positioning and risks obscuring alternative, and more complex, explanations of ADHD which would be more helpful. The limited nurture/nature axis around which the ADHD debate revolves constrains our understandings of the condition and, potentially, restricts the adoption of more holistic and complex ways of understanding it. In turn, this, potentially, curtails the provision of appropriate ways of providing care and management interventions that support families.

The pro-active stance taken by mothers in advocating for their children can be contrasted with the stance taken by fathers, at least in this study. Partially supporting research by Singh (2003), fathers are more reluctant to pursue an ADHD diagnosis or, at least, are less active in pursuing such a diagnosis. It may be helpful for health practitioners to pay more attention to fathers' accounts of their children's condition and be aware of the issues arising. As Singh (2003) suggests, it is possible that in privileging mothers' accounts in the clinical evaluations, only a partial evaluation can be made. Fathers' accounts, potentially, provide alternative perspectives on boys' 'problem behaviours'. For example, many of these behaviours, hyperactivity, in particular, were not formulated as problematic, but,

indeed, within a work context, were framed as helpful and enabling. Increased attention to fathers' accounts is recommended in light of the fact that (some) fathers claim to have (their own) experiential knowledge of the disorder, and, also, a majority of the fathers in this study, at least, valued certain ADHD traits. A different framing of the disorder could provide a useful way of reconceptualising the condition in less negative terms.

Finally, and perhaps of most significance in terms of communication, clinicians might be reminded that parental accountability for their children's conditions is invoked both *prior to* diagnosis and *post* diagnosis. All the parents in this study reported feeling under surveillance by others, including medical professionals, even after diagnosis, and, in particular, around issues of medication. Supporting findings by Singh (2004), Blum (2007) and Gray (2008), the parents in this study attended to issues of accountability in relation to their children's medication.

Therapeutically, a more meaningful offering of support for parents might be in acknowledging this moral positioning and maintaining a professional and empathic openness to and understanding of the constraints it places on parents not only before but also after diagnosis.

10.4 Reflections on the findings and possible future research

Fragmented, fluid and chaotic selves: Clarity or confusion?

A key theoretical premise to this research, and one which informs the drawing of conclusions, is that identities are not fixed, coherent and unitary entities, but are fragmented, fluid and in a state of 'flux' (Burr, 2003). A key conclusion from this research is that parents draw on various cultural resources to formulate themselves as good parents depending on the demands of the situated interaction. Further to considerations by Terry (2010) and Crossley (2003), I, too, speculate as to the clarity of such findings and their necessary theoretical

underpinnings to the general public. In rejecting realist and humanist assumptions of identity, a social constructionist account can, perhaps, be alienating for individuals not trained in the discipline. Although, I might, myself, reject essentialist notions of self, 'phenomenological and experiential realities of life' (Crossley, 2003) are ones that are intuitively meaningful for the majority of lay individuals. Presenting identities as fragmented, and in a state of flux, may 'confuse more than it helps' (Terry, 2010:235). I raise this as a reflection, and possible limitation, of the research because I am currently wondering how to meaningfully, but honestly, summarise these research findings for the participants, as promised. A discursive account of discussion groups and interviews could (quite probably) be meaningless, and, quite possibly, offensive. As Potter and Hepburn (2012:566) point out participants are invited to take part in research because they are formulated as 'being in a special epistemic position with respect to their own conduct'. However, this is later disabused through the deconstruction of their accounts. I, partially, resolve this tension by returning to the consideration raised by Jones (2003) and referred to in Chapter 4, that in theorising interviews and discussions as joint constructions, participants' interpretations of what occurred within the research situation have no more validity than the researcher's.

Absences

This research is a small-scale study to investigate parents' accounts of their experiences of having a child with an ADHD diagnosis. The relatively small sample size prohibits the generalisability of the findings to all parents of children with an ADHD diagnosis. Similarly, the research does not seek to make claims about the representativeness of the sample to a wider population of parents with ADHD. As discussed in the methodology section, following discursive traditions, demographic parameters were not placed on participant recruitment, nor was such information recorded as part of the study. However, it is noted that this sample was fairly

homogenous, in that, all participants, bar one, were white and, all, bar one, were in heterosexual, married relationships.

This is raised as an issue for reflection because the significant finding of this research is that parents' invocation of the 'good parenting' identity attends to issues of moral accountability. As outlined in Chapter 3, 'good parenting' is very much aligned with current conservative discourse, which constructs strict formulations of good parenting; emphasising, specifically, marriage, stability and the presence of an authoritative father. As Gillies (2005) points out, 'good' parenting discourse is infused with middle class values, while 'deficit' parenting discourse is aligned with working class and marginalised families.

These formulations of what constitutes 'good parenting' might have implications for who volunteers for a research project relating to parenting and ADHD, especially a research project identified as emanating from a university context. Additionally, all participants were recruited through parent support groups, and, so, they are understood to be, at least partially, engaged in discursive practices (via the support group) which seek to normalise their parenting behaviour. It is worth reflecting on parents who lie outside these normative constructions of 'good parenting'. The parents who volunteered for this study might have access to different linguistic resources than parents who did not volunteer. It is notable that the parents in this study make relevant subject positions such as the expert mother, the expert father, the professional mother, the out at work father, the emotionally strong father, the coping mother. What subject positions are available for those parents who have no access to 'expert' knowledge (other than the experiential kind), who are out of work, who have had their children taken off them, who are deemed unable to cope?

Similarly, many of the subject positions in this study are worked up vis-à-vis their partner's position so they are relational. For example, the emotionally strong father is formulated in contrast to a more emotionally affected mother; the knowledgeable and competent mother is formulated in contrast to a less competent father.

Essentially, however, what is being formulated is a compatible and effective parenting team, a discursive resource which the parents in this study have access to as part of a co-habiting couple. This leaves open the question of how single parents might 'talk up' a team (or if they do).

Another 'absence' in the study is daughters. It is striking that not one of the children of these parents is female. Clearly, this might be reflective of the disproportionate bias towards boys in diagnosis and it would be interesting to know whether parents of girls with an ADHD diagnosis are proportionally represented in support groups. However, it clearly raises consideration of whether parents of daughters with an ADHD diagnosis are as morally accountable with regards to their children's ADHD as parents of boys with an ADHD diagnosis. As outlined in Chapter 2, boys typically display more overt symptoms of ADHD than girls, who tend to develop internalising symptoms, such as anxiety and depression (Quinn, 2005). The externalising and, so-called, disruptive behaviour displayed by boys is more likely to receive negative attention and judgement (Horton-Salway, 2012; Ohan and Visser, 2009). Additionally, the historic propensity to study problematic male populations and the foregrounding of boys' behaviour in relation to ADHD within the literature renders girls' behaviour invisible (Bailey, 2009). This invisibility, quite feasibly, extends to parents of girls with an ADHD diagnosis, which might explain their absence within this research study (and possibly within support groups).

Clearly, a starting point for future research would be to focus on these absences. For example, future research could explore the way parents of daughters with an ADHD diagnosis talk about their experiences. It would be interesting to examine the discursive resources which are available to these parents and to analyse the subject positions which are made relevant by such parents. As I discuss, the parents who partook in this study were recruited through support groups, suggesting their engagement with both the ADHD category and with parenting discourses. Future research could explore the meaning of ADHD to parents who are not so engaged. It would be interesting to examine the discursive resources available to parents who might not so easily be able to draw on the good parent subject position, and those parents who reject the ADHD category (although I acknowledge recruitment would be difficult).

Maternal focus

The privileging of mothers over fathers in existing literature has been emphasised throughout the thesis, and, certainly, an aim of this research was to provide an equal focus to fathers. However, in writing up the thesis, it became apparent that to do justice to the material on mothers, two chapters were needed, rather than the one chapter for fathers. This is disappointing, but is, perhaps, not surprising. Despite a separate plea for fathers to take part in the research (see Appendix A), the project was set up to investigate the talk of *parents*. Naively, I had anticipated that I could separate maternal and paternal identities and the practice of 'mothering' and 'fathering'. I had not really considered what 'parenting' meant. As Sunderland (2006) highlights, despite a fairly recent shift to 'parenting' as a verb, fathers are not really addressed within contemporary discourse and discursive practices. The majority of childcare is still carried out by women, and traditional understandings of mother as main parent and father as part-time parent are still very dominant (Sunderland, 2006, 2000). This, she argues, is supported by

analysis of discourse. In her own study, Sunderland (2006) focuses on the language of parenting magazines and reveals that fathers' participation with childcare is described using verbs such as 'play', 'help' and 'share', which very much positions fathers as not only the part-time parent, but also 'mother's bumbling assistant'. Sunderland's interpretation of the meaning of parenting is supported by the findings of this research. As I indicate in Chapter 8, fathers are very much positioned as the 'assistant' parent. With the exception of the interview with Michael, all other interviews with fathers were conducted with their partners. This contrasts with the five one-to-one interviews I conducted with mothers. It is striking that within the individual interviews with mothers much of the talk is concerned with constructing accounts which privilege the status of mothers as main and (expert) caregiver. However, even within the couple interviews, accounts of maternal primacy in dealing with the children are privileged. The aim of this research was to investigate how parents draw upon culturally available resources in describing their parenting experiences. The foregrounding of the maternal in parents' accounts of parenting would, therefore, suggest that the status quo of gendered caregiving practices is maintained through the 'constant repetition and integration into people's lives' of these discursive resources (see Terry, 2010:224). The gendered imbalance revealed in analysis also suggests that fathers have fewer resources available for them to draw upon in formulating their identities as good fathers.

Future research could build on this very small scale study of fathers' talk about their experience of ADHD. It would be interesting to compare the talk of fathers of daughters with an ADHD diagnosis with that of fathers of sons. It would be interesting to examine whether fathers make relevant the disciplining father subject position in talk about their daughters as much as they do in talk about their sons. A comparison of the talk of individual fathers with that of fathers in a couple

might also be insightful in terms of the discursive resources that are employed individually and jointly.

10.5 Concluding remarks

In light of the focus of the research and the absences considered in the last section, this research does not seek to make any claims to generalisability, but aims to provide insight into how some parents make sense of their experiences of having a child with an ADHD diagnosis by drawing on socially and culturally produced understandings of parenthood and childhood. Whilst acknowledging that parents who are positioned outside normative representations of what constitutes the good parent may be more constrained by the availability of linguistic resources when formulating 'good parenting' identities, it is hoped that the insight provided by the thesis helps to open the debate about childhood mental health categories. This thesis argues for a move away from an understanding that such categories refer to objective and morally neutral scientific truths that exist outside of language. Instead, it calls for an appreciation of the constitutive power of such categories, particularly with respect to ADHD, and how they are implicated in the formulation of moral identities.

I would like to repeat the point made in the introduction that, despite challenging the neutrality of such medical categories, the aim of this research is not to challenge the 'reality' of ADHD per se. Neither is it the aim to undermine parents' accounts of their experiences of having a child with ADHD. Its aim is to consider how psychopathologies, such as ADHD, are discursively produced, debated and reproduced by parents.

Finally, as I discussed earlier, parents were invited to take part in this research because they were considered to have a 'special epistemic position' (see Potter and Hepburn, 2012) with regards to their own experiences of having a child with

ADHD. With this understanding, they were very generous with their time and their stories and the accounts they provided were variously, distressing, moving, poignant, funny, warm and, always, affectionate. As is typical with discursive approaches, I have deconstructed their accounts without (arguably) informed permission. My version of their stories emphasises accounts of extreme, often violent, behaviour, victimisation, blame and discipline. Therefore, I would like to end this thesis with some quotes from some of the parents, which came towards the end of their interviews, and which are representative of sentiments expressed by all the parents in this study. Although I acknowledge the discursive function of both the content and positioning of such quotes at the end of accounts of distress and difficulty, I wish to leave these unanalysed.

Michael:

Michael: *I think that uh even though M 's ADHD can be frustrating at times it's also been quite rewarding as I've been saying with some other characteristics and so uhm you know so overall I'm you know it's quite a pleasure to be his dad (laughs)*

Rachel:

Rachel: *but he is lovely he's absolutely gorgeous [...]well when he's on when he's being nice or when you're not wanting him to do something else like homework or getting him to do something in your time that is boring you know anything anything like that you have a battle it will be awkward around it but you know he's just delightful he's absolutely delightful and very creative and then and and funny and then you have this rude demanding controlling side which is less easy to to to manage as well uhm but you know when he's on form he's lovely*

Gill and Mick:

Mick: *he constantly surprises me with how how generous and helpful he can be and sharing even though sharing is not his natural instinct*

Gill: *and sensitive [and a drama queen] [...]*

Mick: *as well as being a right pain in the arse (laughs)*

Appendix A: Sample Invitation to Support Group Members

Parents' understandings of ADHD

My name is Alison Davies. I am a PhD student in the Faculty of Health and Social Care at the Open University. My research project has the working title of 'Parents' understandings of ADHD'. My research is particularly interested in the different ways people talk about ADHD; in this study, specifically parents. I am interested in how parents talk about their own experiences of ADHD and their interpretations of their child's problems. If you are the mother or father of a child with ADHD, then I would be very interested to hear from you. I am particularly keen to recruit fathers as their voices tend to be absent from existing research.

Can you help?

I am really keen to find volunteers who are willing to give up between 1 and 2 hours of their time to take part in either a focus group or an interview (or both) where they will be invited to talk about their experiences of ADHD.

I am hoping to run one discussion group (of approximately 6 volunteers) and then several individual or couple interviews (as I say above, it would be great if fathers would volunteer as well as mothers). I expect both the discussion group and the interviews to last about an hour each. I am planning to run the discussion group in late February/March 2011 and the interviews between April and June 2011. I am hoping to carry out the discussion group at St Albans Children's Centre and the interviews in the most convenient place for you; either at the centre or in your homes.

If you are interested in being involved, or you have further queries, then please get in touch. My details are:

Alison Davies
HSC
The Open University
Walton Hall
Milton Keynes
MK7 6AA

Email: alison.davies@open.ac.uk

Tel. no 07581781724

I will then get back to you with further details about the project and to arrange a convenient time.

Thanks for your time.

Appendix B: Sample Information Sheet

Parents' constructions of ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

Information Sheet

Alison Davies, PhD Student
The Open University, Milton Keynes
alison.davies@open.ac.uk
07581781724

What is the research topic?

I am a PhD student in the Faculty of Health and Social Care at the Open University. My research is interested in the different ways people talk about Attention Deficit Hyperactivity Disorder (ADHD); in this study, specifically parents. I am interested in how parents talk about their own experiences of ADHD and their interpretations of their child's problems. I am particularly keen to recruit fathers as their voices tend to be absent from existing research.

How will I collect my data?

I intend to run one focus group (of approximately 6 volunteers) and then several individual or couple interviews (as I say above, it would be great if fathers would volunteer as well as mothers). I expect both the focus group and the interviews to last about an hour each. I intend to conduct the focus group January/February 2011 and the interviews between April and June 2011. I will audio record the focus group and the interviews and then transcribe the discussions into written form before analysing them. The focus group will take place in the centre where the support group is held, the interviews can take place wherever is most convenient for you; either at the centre or in your home.

What can you do to help?

It would be great if you could volunteer for the focus group and/or the interviews (you can do both or just one, whichever you prefer).

Will the information you give me remain confidential?

Each person who takes part in this research will be asked to sign a consent form both before and after the focus group and interview. Your personal information will remain confidential, and in writing up my research report, pseudonyms will be used throughout to assure anonymity (unless of course you expressly desire your name to be used).

What will happen to the information I collect?

Data collection will comply with the Data Protection and Freedom of Information Acts. All the collected material, written and electronic (field notes, recorded interviews) will be safely stored on password protected computers in locked rooms. Hard copies will be safely stored in locked cabinets when not in use.

Does this research conform to ethical guidelines?

The ethics for my research study has been approved by the Open University's Human Materials and Participants Ethics Committee, which has examined my research proposal and documentation. My research is also being conducted in accordance with ethical guidelines issued by the British Psychological Society (2010).

Can you withdraw from the research process?

You have the right to withdraw from the research up to two weeks after the data collection. You also have the right to ask me to omit, edit, or restrict part or all the collected data.

Will there be any risks involved in participation?

I do not anticipate any physical or psychological risks associated with participating in this study. However, I am aware that talking about your experiences of ADHD may be unsettling. Should you feel upset during any stage of the research process, then please let me know and I will respect any decision you make with regard to continuing with the research. I will endeavour to make the process as safe as possible for you and ask that you only disclose information you feel comfortable sharing.

How can you find out about the research?

I will be available after the focus group and interviews to answer any questions or listen to any comments you may have about the research.

For those of you who take part in the focus group, and who are interested, I can give you a transcript of the discussion that takes place (in anonymised form). Similarly, for those of you take part in the interviews, I can give you a transcript of the interview that you take part in. Alternatively, or additionally, I can give all of you a summary of my main findings when I have finished writing up my research report. If you are interested, please get in touch via the contact details at the top of the form.

Who do you contact if you have any questions?

If you wish to contact me to raise any questions or comments about the research please contact me at the email address or telephone number given at the top of the information sheet.

If you wish to talk to someone else about the research you can contact

Primary Supervisor

Dr. Martin Robb
Faculty of Health and Social Care
The Open University
Walton Hall
Milton Keynes
MK7 6AA

Email: m.p.robbs@open.ac.uk

Director of Post-graduate Studies

Dr. Lindsay O'Dell
Faculty of Health and Social Care
The Open University
Walton Hall
Milton Keynes
MK7 6AA

Email: l.odell@open.ac.uk

It is really important that you understand and are comfortable with the research, so please read the information sheet and consent form before you decide if you want to take part. I will contact you in the next few days to check if you still want to take part, and if so, to arrange a convenient date for the focus group. There is one form relating to the focus group and one form relating to the interviews. If you'd like to participate in both stages of the research, you will be asked to complete both forms when we meet for the focus group, and before we start the discussion. If you just want to be involved in one stage, either the focus group or interview, then you will be asked to complete the relevant form, again, when we meet and just prior to the discussion/interview.

Thank you for your time and attention.

Appendix C: Sample Consent Form



The Faculty of Health and Social Care, The Open University Consent form (interview/focus group)

Parents' constructions of Attention Deficit Hyperactivity Disorder (ADHD)

(name of project)

Agreement to Participate

I,

(print name)

agree to take part in this research project.

I confirm that I have read and understand the information sheet for this project, and have had the opportunity to ask questions

I have been informed that I may decline to participate at any point by simply saying so.

I have been assured that my confidentiality will be protected and

I understand that all the information relating to me will be anonymised in any reports and publications so that I cannot be identified.

I agree that the information that I provide can be used for educational or research purposes, including publication.

I understand that if I have any concerns or difficulties I can contact:

Alison Davies

at:

Faculty of Health & Social Care
The Open University
Walton Hall, Milton Keynes
MK7 6AA
Email: Alison.davies@open.ac.uk
Tel: 01908 654315

If I wish to talk to someone else about any aspect of my participation in this project, I can contact the Director of Post-graduate Studies at:

Dr. Lindsay O'Dell
Faculty of Health & Social Care
The Open University
Email: l.odell@open.ac.uk



I agree to take part in the interviews/focus groups related to this project

Name of interviewee Date Signature

.....

Researcher Date Signature

.....

I have taken part in the interviews/focus groups related to this project and I assign permission for my contribution to be used in education, research and publication.

Name of interviewee Date Signature

.....

Researcher Date Signature

.....

***Thank you for taking part in this study
Please let us know if you would like a copy of this signed consent form***

Appendix C: Names of participants

Focus group 1

Ingrid

John (Ingrid and John are a couple)

Paula

Linda

Julie

Diane

Sulinder

Focus group 2

Alan

Jane (Alan and Jane are a couple)

Mick

Gill (Gill and Mick are a couple)

Rachel

Individual interviews

Caroline

Rachel

Paula

Michael

Julie

Kim

Christine

Couple interviews

Gill and Mick

Alan and Jane

Ingrid and John

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